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A Study of Spiritual Care among Boys in Residential Care

A ~~Dissertation~~ Professional Project

presented to

the Faculty of Claremont School of Theology

In Partial Fulfillment

of the Requirements for the Degree

~~Doctorate~~ Doctor of Ministry

by

Diane Heaton Schmitt

May 2009

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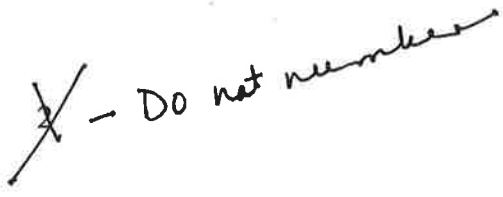

This professional project completed by

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has been presented to and accepted by the faculty of Claremont School of Theology in partial fulfillment of the requirements of the

DOCTOR OF MINISTRY

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May 2009

Due to extenuating circumstances, final edits were not completed for this project.

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Abstract

A Study Of Spiritual Care Among Boys In Residential Care

by

Diane Heaton Schmitt

Would the creation and implementation of a spiritual care program on the McKinley Children's Center campus reduce the incidents and severity of the negative and often self-destructive behaviors of the severely emotionally disturbed, abused, and traumatized boys living there? ~~I wondered?~~ The spiritual care program that this project describes considers the discipline of pastoral/spiritual care through the lenses of trauma and attachment theory. Central to this project is the assumption that spiritual care has the capacity to create attachment healing in traumatized boys. The supposition is that once attachment healing begins, the need to engage in negative, self-destructive behaviors will diminish. The outcomes of this project appear to uphold that assumption given the reduction in the occurrences of the most severe behaviors. However, the outcomes for the less severe behaviors showed an increase in their occurrences, putting the initial assumption in question. Therefore, the concluding suggestions for further investigation into the viability of the outcomes are appropriate.

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Introduction

The Problem and Hypothesis

Boys in residential, out-of-home care at McKinley Children's Center (MCC) engage in negative and often self-destructive behaviors. This project investigates the hypothesis that a spiritual care program will diminish the occurrences of negative and self-destructive behaviors by these boys.

The Importance of the Problem

MCC is a level twelve residential care facility that houses up to sixty-six abused and severely emotionally disturbed (SED) boys aged six through eighteen. As with most residential care facilities, MCC's goal is to help its residents manage their behaviors and heal their psychosocial and spiritual wounds so that they function well enough to move to a less restrictive level of care and contribute positively to society. Similar types of residential care facilities exist all over the world; hence, while this project will focus specifically on MCC, the problem –and presumably the need—is global.

The boys at MCC are not living there by choice; their county's social services have sent them there to escape the abuse or neglect inflicted on them at home. The food, shelter, clothing, a bed to sleep in, and a safe living environment that most of us can take for granted are not available to these boys. Their behavior reflects this.

Through my years of serving children, I have learned that their behavior reflects their feelings. When children feel loved, nurtured, and safe, they flourish. When they do not, they act out in self-destructive, negative ways. Unfortunately, safe, nurturing environments rarely occur in residential care. I say this as a professional; I am the executive director of treatment at MCC,

a licensed local pastor in the United Methodist Church, a credentialed K-12 school counselor, and a licensed marriage and family therapist specializing in adolescents and addiction.

If the boys of MCC indeed act out the woundedness acquired in their abusive upbringing by engaging in negative and often self-destructive behaviors, and if residential care facilities do not provide the opportunity to change this, then this thwarts the goal of helping these boys move to a less restrictive and therefore presumably more nurturing living environment. A child who continually engages in these negative and often self-destructive behaviors is rarely offered the opportunity to move to a less restrictive living environment; it is the child who has learned to manage his or her behavior and act in a more positive and constructive manner who is offered the opportunity instead. For the child who is not chosen to move, this simply reinforces the hopelessness of his or her situation, and the cycle of negative and destructive behavior continues with increased vigor.

However, if the child can find a way to reduce his negative, often self-destructive behaviors, such as by participating in a spiritual care program offered on campus, and regain some hope of moving to a less restrictive environment, maybe even home, then the child can often more quickly achieve the goals of residential care.

Thesis Statement

By participating in a spiritual care program on the MCC campus, children fulfill some of their previously unmet psychospiritual needs. One way of measuring this is in a decrease in their negative and often self-destructive behaviors.

In this project, I propose that increasing a child's spiritual life enhances their ability to form and maintain attachments, an ability that abuse has often stymied, which is therefore particularly important to foster among children who have experienced trauma. Lack of

attachment increases the child's need for defenses, which they frequently express through negative and self-destructive behaviors. Hence, if it is somewhat possible to heal trauma-inflicted attachment difficulties through spiritual care, then the resulting attachment may evidence itself in a decrease in self-destructive behaviors and a reduction in the number and severity of the documented Serious Incident Reports (SIRs).

Methodology

I conducted a review and comparison of the structure and content of the spiritual care programs of two similar local residential care facilities as well as MCC's current spiritual care offerings. After this, I implemented on the MCC campus a modified version of the Reverend Michael Friesen's spiritual care program.[1] Friesen created the model used for the ongoing spiritual care program at St. Joseph's Home for Children, a residential care facility in Minnesota. This model is described in more detail later in this project.

In the next stage, I examined possible correlations between participation in the spiritual care program and decreases in negative, often self-destructive acting-out behaviors in all boys residing at MCC, using the Serious Incident Report (SIR) system. This system tracks all incidents in which a boy has been physically restrained from doing something or in which a boy has been involved in a behavior or activity that has been hurtful to him, to others, or to property. First, I established a baseline level of SIRs in all boys on the MCC campus, signaling the beginning of the project. Then after three months, when concluding the project, I again reviewed the number and level of seriousness of all SIRs to evaluate the success of the spiritual care program in decreasing, campus-wide, negative and often self-destructive acting-out behaviors among the boys.

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[1] Michael Friesen, *Spiritual Care for Children Living in Specialized Settings: Breathing Underwater* (~~Binghamton:~~ ~~The~~ Haworth Press, 2000).

New York!

Pastoral

Next, I separated the recorded SIRs into three categories, which only included those boys who attended the spiritual care program. The first is the SIRs of those boys who have participated in the spiritual care program on a regular basis (meaning that they have attended at least nine spiritual care activities each month). The second is SIRs of those boys who have participated in the spiritual care program occasionally (participating in four to eight of the spiritual care opportunities offered each month). The third is SIRs of those boys who rarely participated in the spiritual care program (participating in one to three spiritual care opportunities each month). I then compared and contrasted responses of boys in these three categories to identify any salient differences in the number or severity of reported SIRs.

Over the course of the three-month study, I collected the data from all sources (the amount and severity of SIRs campus-wide both pre- and post-project, and the amount and severity of SIRs for the three groups of boys attending the spiritual care program). I then reviewed and examined this data for any possible correlations between participation in the spiritual care program and decreases in negative, often self-destructive acting-out behaviors. I report all results in chapter six and make suggestions for further study of this issue in chapter seven.

Definition of Major Terms

Less Restrictive Living Environment: Refers to congregate care that allows children to move from a higher, more restrictive level of care to a lower, less structured and less restrictive level of care. There is a philosophical, financial, and policy-driven push to move children as rapidly as possible to this lowest and least structured level of restrictive care, with little consideration for their psychological and spiritual level of health and healing.

Residential Care: A type of congregate, out-of-home care in which SED children live, often in multiple barracks-style residences, usually referred to as cottages, surrounded by a fence and usually grouped with a non-public school on the same grounds. There is twenty-four hours a day, seven days a week staffing on the grounds as well as in the barrack-style residences. The children live, eat, and go to school in this fenced-in area. The children are not here by choice but by placement of a county or state child welfare agency. The children cannot leave by choice usually they can leave only under the direction of the same agency that placed them there or, occasionally, at the request of a family member. Typically, they receive all the services they require on-site: medical, psychological, and social services. They also have access to any available spiritual services on the grounds of these facilities. These facilities rank from level 1 to level 14. The higher the level, the more restricted the structure and staffing patterns as well as the personal freedom and rights of the children.

Serious Incident Reporting (SIR) System: A behavior tracking system designed and monitored by the Department of Children and Family Services of Los Angeles County. Within twenty-four hours of any incident of destructive acting-out behavior taking place, counselors record it into the Severe Incident Report (SIR) system that documents the nature and severity of the situation.

Serious Incident Report (SIR): The report entered into the SIRs.

Severely Emotionally Disturbed children (SED): Describes children traumatized in one or multiple ways. Most if not all of these children carry a mental health diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), commonly posttraumatic stress disorder (PTSD).[2] The trauma typically affects every area of a child's

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[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* ~~Fourth Edition~~ 4th ed. (Washington DC: American Psychiatric Association, 1994). ↑ DSM-IV,

functioning, including school performance and social interactions, as well as their psychological, physical, and often cognitive and spiritual development. As a result, on average these children are two developmental levels behind their non-traumatized counterparts.

Spiritual care: Spiritual care has a rich and diverse history and has been defined in a multitude of ways. For example, Clebsch and Jaekle define pastoral care as "the ministry of the cure of souls" which "consists of helping acts, done by representative Christian persons directed toward the healing, sustaining, guiding and reconciling of troubled persons whose troubles are in the context of ultimate meanings and concerns."[3] These four functions will be used foundationally in this project as further described in Chapter 4, although additional functions have been identified.

For example, while Emmanuel Lartey hails Clebsch and Jaekle as groundbreaking pioneers in the field of pastoral care and elaborates on their definition and the four functions, of healing, guiding, sustaining and reconciling, he proposes additions and offers criticism.[4] Although Lartey claims that the Clebsch and Jaekle definition of pastoral care has "become more or less a standard definition of pastoral care," he goes on to say that it suggests "pastoral care is *ipso facto* a Christian term" and does not recognize other religious traditions.[5] Furthermore, he posits that the definition is somewhat generic in nature.[6] However, Lartey's own definition of spiritual care is "the expression of spirituality in relation to self, other, God, and creation," which can also be criticized as generic.[7]

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[3] William A. Clebsch and Charles R. Jaekle, *Pastoral Care in Historical Perspective* (Northvale: Jason Aronson ~~Inc.~~, 1994), 4.

[4] Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London: Jessica Kingsley Publishers, 2003), 21-68.

[5] Ibid., 21-22.

[6] Ibid., 21.

[7] Ibid., 11.

Nevertheless, Lartey goes on to mention several other definitions for pastoral care, including one from Howard Clinebell, who he describes as "a guru of Western pastoral care and counseling," a description with which I quite agree.[8] Howard Clinebell defines pastoral care and counseling as a process, which involves "the utilization by persons in ministry of one to one or small group relationships to enable healing, empowerment and growth."[9] When Howard Clinebell explained the healing techniques of pastoral counseling to me, he emphasized connection.[10] He spoke to me of building relationships with my clients while creating empowering opportunities for them along the journey.[11]

Alastair Campbell and Ed Wimberly also speak to the relationship-building aspect of pastoral care.[12] Wimberly defines pastoral care as the "bringing to bear upon persons and families in crisis the total caring resources of the church."[13] He upholds Clebsch and Jaekle's definition of pastoral care but expounds on it by adding his own four resources of the process.[14] The four resources he includes in pastoral care are worship, care, nurture, and witness, all done within the context of liberating individuals and families from crisis.[15]

While all of these definitions have great merit, for this project, I have chosen another. I have chosen to define spiritual care as the formation of relationships that communicate[16] and bask in the awakening[17] of oneself to be a child of God,[18] thereby healing his/her brokenness

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[8] Lartey, 22.
[9] Howard Clinebell, *Basic Types of Pastoral Care and Counseling: Resources for Ministry of Healing and Growth* (Nashville: Abingdon Press, 1984), 25-26.
[10] Clinebell, Conversation at his Santa Barbara home, spring, 2004.
[11] Clinebell, Conversation at his Santa Barbara home, spring, 2004.
[12] Lartey, 23-24.
[13] Edward Wimberly, *Pastoral Care in the Black Church* (Nashville: Abingdon, 1979), 18.
[14] Ibid.
[15] Ibid., 18-38.
[16] Daniel Grossoehme, *The Pastoral Care of Children* (~~Binghamton: The Haworth Press~~ New York: Haworth Pastoral Press, 1999), 5.
[17] James W. Fowler, *Faith Development and Pastoral Care* (Philadelphia: Fortress Press, 1987), 21.
[18] Grossoehme, 5.

thus[19] enabling this person to live with and express[20] hope through his/her life experience, past, present and future. This definition is a combination of my own ideas and borrowed ideas, as footnoted, from a variety of authors including Daniel Grossoehme, Howard Clinebell, Emmanuel Lartey, and James Fowler. However, often their definitions are for pastoral care vs. spiritual care, which needs to be expounded on.

Paget and McCormack refer to a terminology shift when they observe the change that has occurred recently in the language used in pastoral care, a change that responds to the growing need for and awareness of religious diversity.[21] In honoring this change of language, pastoral care is now often referred to as spiritual care.[22] I will use these terms interchangeably in this project with respect to the changing terminology in the field.

Grossoehme highlights Fowler's definition of spiritual care as being too broad.[23] Fowler defines spiritual care as "all the ways a community of faith, under pastoral leadership, intentionally sponsors the awakening, shaping, rectifying, healing and ongoing growth … of Christian persons."[24] Grossoehme seeks to refine that definition by saying that pastoral care is "the formation of relationships with persons of all ages that communicate … and bask in knowing one's self to be a child of God, so that all persons are enabled to live through their life experiences and to understand them in terms of their faith."[25] Lawrence Holst defines pastoral care as "the attempt to help others, through words, acts, and relationships, to experience as fully as possible the reality of God's presence and love in their lives." Notably none of these

Basic Types ?

[19] Clinebell, 26.
[20] Lartey, 11.
[21] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge: Judson Press, 2006), 18.
[22] Ibid.
[23] Grossoehme, 4.
[24] Fowler, 21.
[25] Grossoehme, 5.

definitions directly reference the business of traumatized children who are unable to form attachments due to developmental issues and an inability to trust.[26]

Spiritual Care Program: At MCC this is a collection of services, including Sunday evening chapel worship service with four additional groups a week focused on spiritual and/ or religious themes, expressed through music, sacred text study, and meditation exercises as well as other activities, all created to provide an ecumenical, non-sectarian and age-appropriate, spiritually rich healing environment. This is all done undergirded with Clebsch and Jaekle's four functions of pastoral care as mentioned previously and described in greater detail in Chapter 4, as well as through the lenses of trauma and attachment theories.

Work Previously Done In the Field

While academic and empirical research exists on the spiritual needs of abused children in a multitude of arenas, relatively little is known about how the constraints of residential care affect such needs. The Reverend Michael Friesen's *Spiritual Care for Children Living in Specialized Settings: Breathing Underwater* is a particularly helpful resource, so much so that, with his permission, I have used his model for spiritual care in residential settings to develop this project. Reverend Friesen's model is reviewed in full in chapter three.

Undergirding Friesen's model is Erik Erikson's developmental stage theory, which describes the spiritual needs of children at different times in their lives.[27] Though Friesen often alludes to attachment theory and trauma theory in his book, he never mentions either directly.

The literature on the pastoral care of children only occasionally mentions attachment. For example, in a section of one chapter, Andrew Lester discusses how to provide a sense of

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[26] Grossoehme, 5.
[27] ~~Michael~~ Friesen, 87-89.

belonging for a child in crisis as an act of pastoral care.[28] In his book, *The Pastoral Care of Children*, Daniel Grossoehme's chapter on Spiritual Friendship considers attachment as being essential for healing.[29] While Jane Middleton-Moz writes frequently and eloquently in *Children of Trauma* about the need for attachment to facilitate healing, she does not address spiritual care.[30] Judith Herman, does not address spiritual care for children either even though in her book, *Trauma and Recovery*, she dedicates a chapter to abused children.[31] She describes how abuse equates with trauma and deprives children of the opportunity to develop attachment or a sense of self but she does not correlate any of that with spiritual care. Thus, overall the research and literature that combines pastoral or spiritual care, attachment theory, and residential care is minimal.

However, two books do emphasize the combination of spirituality and residential care. Paul Knowlton, in his book entitled, *The Original Foster Care Survival Guide*, speaks to the children about finding a spiritual connection for survival.[32] Perhaps most thorough is Thomas Everson, with his training program designed for Boys Town, a nonprofit organization that works with high-risk children in various settings including residential care. His book, entitled *Fostering Spiritual Growth Among At-Risk Youth*, is saturated with information and ideas about spiritual development, the spiritual life, and ways to promote spiritual growth in at-risk children.[33] However, he postulates his ideas in an arena that is friendly toward religious teachings and does not address how these ideas might work in secular, government-supported residential care.

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[28] Andrew Lester, *Pastoral Care With Children In Crisis* (Philadelphia: Westminster Press, 1985), 57-59.
[29] Grossoehme, 64-74.
[30] Jane Middleton-Moz, *Children of Trauma* (Binghamton: The Haworth Press, 2000).
[31] Judith Herman, *Trauma and Recovery* (New York: Basic Books, 1997), 96-115.
[32] Paul Knowlton, *The Original Foster Care Survival Guide* (Lincoln: iUniversity, 2005).
[33] Thomas Everson, *Pathways, Fostering Spiritual Growth Among At-Risk Youth* (Boys Town: Boys Town Press, 1993).

MCC does not have the freedoms of Boys Town. MCC's funding comes mainly from the U.S. government and is consequently heavily laden with restrictions, many specific to the separation of church and state. Hence, this project endeavors to extrapolate from the previous work done on the intersection of trauma, attachment, and spiritual care whatever might be useful at MCC to create an ecumenical and non-sectarian spiritual care program that might augment the treatment currently provided by MCC.

Scope and Limitations of the Project

Given that I am tailoring this program to MCC and implementing it at MCC, a limitation inherent in this project is that we may not be able to generalize its findings from MCC to other residential facilities. Not all residential facilities face the same constraints as MCC. For example, MCC has specific funding streams, each with its own limitations based on local, county, state, and federal governmental regulations. In addition to the regulations related to the separation of church and state, these limitations include the prohibition against promoting a specific religion. Though the spiritual care program is intended to be non-sectarian, the capacity of the author and MCC to provide a thoroughly multi-religious program is limited. For example, the Christian orientation of the author of this project and of much of the literature in pastoral care and counseling limits the author's capacity to expose MCC residents in the spiritual care program to the wisdom and spiritual practices of other religious traditions.

The brevity of the project's research period also prevents me from easily generalizing the findings. Although all the boys residing on the MCC campus were involved in this project via the SIR system, the project data-gathering period spanned only three months, from September 1 through November 30, 2008. Several extraneous variables may influence the type and severity

of SIRs on the MCC campus during this time, including the stressors of beginning a new school year and the onset of the winter holiday season.

Chapter Outlines

This project consists of six chapters, plus this introduction that describes the problem to be examined.

In this brief introduction, I introduce MCC and present an overview of the importance of the problem this research discusses. I highlight the cycle of negative, self-destructive behaviors that often affects the boys living at MCC and propose ways to perhaps interrupt or end this cycle. I state in the thesis of this project, how the addition of a spiritual care program to the curriculum of MCC would interrupt or end the cycle. The methodology for measuring the possible outcomes is also discussed in chapter one, along with the definitions of major terms used throughout this project. In an effort to provide context, I review work previously done in this field. An assessment of the scope and limitations of this project conclude chapter one.

Chapter ~~one~~ 1 builds on the Introduction by further describing MCC. I review the history of MCC, comparing it with the present demographics, and review the current programs offered at MCC, which together illuminate the need for a spiritual care program.

A brief description of spiritual care programs offered in residential settings geographically near MCC launches chapter ~~two~~ 2. However, chapter ~~two~~ 2 is focused on the description of two other models of spiritual care programs offered in residential settings, one of which created a foundation for the spiritual care program implemented at MCC in this project.

Chapter ~~three~~ 3 further seeks the answer to the question of why children need spiritual care in residential settings. This chapter develops a theoretical framework for showing how the

relationship between a spiritual care program which addresses the attachment needs of traumatized children can help decrease the acting-out and self-destructive behaviors of such children. This I do by examining trauma theory, attachment theory, and the practice of pastoral care and counseling as seen through the four functions Clebsch and Jaekle describe.[34]

With trauma theory, attachment theory, and the practice of spiritual care in mind, chapter four seeks to explain and describe the design of the spiritual care program implemented through this project at MCC. I explore the difficulties of implementing the MCC Spiritual Care Program including the adaptation made to the Friesen model. Finally, a look at the goals of the MCC Spiritual Care Program and how they are to be achieved concludes chapter four.

The methodology for deriving the outcomes of the project is presented in chapter five. I discuss possible correlations or assumptions relevant to the empirical evidence gathered from these outcomes.

Chapter six explores areas of the research that may have been done differently, for example, finding better ways of controlling for and excluding extraneous variables. Furthermore, possible additions or deletions of components of the spiritual care program model or the structure of the project will be discussed. The concluding remarks of chapter six focus on future aspirations and suggestions for other research resulting from this project.

[34] Clebsch and Jaekle.

Chapter 1

Understanding the Need for and Evolution of McKinley Children's Center

McKinley Children's Center (MCC) is a residential care facility built on a rich history that I review in this chapter to highlight the evolution and need for residential care, as well as to establish a clear baseline picture of how MCC functions currently. MCC is in many ways a legend, having a 108-year history. Nevertheless, residential care itself has a much longer history.

The History of Residential Care

It is unfortunate that there have always been children in need of residential care. Beginning in the Middle Ages, legislation was enacted by the English government to impose legal obligation on the population to provide for such children. The Statute of Cambridge was passed in 1388 in England, requiring the local "manor" to care for needy local children. This marked a profound change.[35] Prior to this legislation, children in need were voluntarily tended to by the local population. Admittedly, this was done to great extent for economic gain, not philanthropy, as able-bodied children were often used as agricultural laborers during this period.[36]

As time passed, society shifted from being agrarian to being industrialized, from living in the countryside to the cities and, as a result, the need for child labor changed. More and more children wandered the streets unattended, and this prompted government intervention. These children were increasingly housed in government-run hospitals. Although the children now had a place to sleep, they were still farmed out into labor-intensive apprenticeships.

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[35] Brian Corby, Alan Doig and Vicki Roberts, *Public Inquiries into Abuse of Children in Residential Care* (Philadelphia: Jessica Kingsley Publishers, 2001), 15.

[36] Ibid.

Occasionally a child would be fortunate enough to avoid this plight by being taken into a monastery or convent. The churches were quite active with this type of support for abandoned or orphaned children prior to the 1500s.[37] However, the financial impact on the churches of caring for these children soon became overwhelming, and to avoid complete depletion of the church's resources, the first Poor Law was passed in 1531.[38] This law was the first of many laws designed to shift the financial and moral responsibility for these children away from the churches.

By the mid 1500s, a series of laws, including the Poor Law, began addressing the issues of destitute children. Unfortunately, most of these centered on giving authority to the local governments to round up all these children and enslave them in some type of work apprenticeships.[39] The motivation for these forced apprenticeships began with cost, pragmatism, and the idea that work was the best cure to the "idleness and mischief" in which these children seemed to exist.[40] This concept was in one way or another the generally accepted norm for how to deal with these children until well into the eighteenth century.

However, in 1552 a hospital was created in London just for destitute children.[41] It was called Christ Hospital, and it provided housing and education, along with all the other basic provisions a child might need. It was the first true childcare residential establishment and soon several other hospitals were built based on the Christ Hospital model.[42] Sadly, by the middle of the seventeenth century, these specialized housing hospitals closed or were used for other purposes. The problem was financial; it just cost too much to take care of the children.

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[37] Corby, Doig and Roberts, 15.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid., 16.
[42] Ibid.

This spawned the re-introduction of the "residential experiment" in England in 1647, which consisted of opening homes in which children could live, an experiment that combined the concept of apprenticeships with the governmentally-funded and run specialized housing hospitals. These structures were called "workhouses."[43] Unfortunately, education was not a component of the workhouse structure; children were taught to work and pay their way. There was a very high mortality rate; for the most part, these houses were overcrowded, and the children were treated poorly.

With the Education Act of 1870, school became compulsory for all children.[44] This significantly affected the viability of the workhouses, given that education took away the time children were needed to work. Thus, the shift away from institutionalized care to a more child-centered care focus began.

In the late 1950 and early 1960s, John Bowlby, the father of attachment theory, and Goffman's concept of "the total institution" helped push the idea of smaller, more community-based, cottage homes to the forefront of care for neglected, destitute, and abused children.[45] The aim now became treatment and education rather than child labor and housing. Admittedly, such care was still in institutions, but most such institutions were re-configured with smaller units, or cottages, each housing ten to twenty children in hopes of creating a more family-like environment.[46] The other option that was explored was to move completely away from the institution to individual families who were to provide foster care. [47]

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[43] Corby, Doig and Roberts, 17.
[44] Ibid.
[45] James Anglin, *Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children* and Youth (Binghamton; The Haworth Press, ~~2007~~ 2003), 9.
[46] Ibid.,10.
[47] Ibid.

For decades, the push for more homelike settings, or in childcare jargon, less restrictive environments, has been the driving force in services to abused, neglected, and abandoned children. Unfortunately, the financial resources needed to provide such care have been minimal.

As was the case in the late 1500s when Christ Hospital had to change its focus due to financial constraints, the desire to provide treatment to children continues to be thwarted by lack of funds. The current goals of residential care are still to provide education, health, and therapeutic services, as well as a healing environment for the children who reside there. However, with the ongoing financial struggles these institutions face, basic care is often all that the children are offered.

History of McKinley Children's Center

McKinley Children's Center is much more than a 30-acre campus that houses and treats children, as its history will show. In January of 1900, McKinley Children's Center was created, though at the time the Reverend Uriah Gregory and his wife named it the Industrial Home Society.[48] This name reflected the times. It was a time in residential care history when the idea of helping orphaned or disadvantaged children centered on training the child to work, with perhaps a bit of education added along the way. The Industrial Home Society consisted of a 33-acre working ranch in Artesia, California, which offered boys the opportunity to work for their keep.[49]

The Industrial Home Society attracted many supporters in Los Angeles, who began the Women's Auxiliary. The members of the first woman's auxiliary were prominent members of the Los Angeles elite, eager to provide an excellent education for the boys and add a mental health treatment component to the residential program, which they did.

Put in quotes and remove italics

[48] Rhonda Beltran, *The History of McKinley Children's Center*, ~~San Dimas, California~~. Photocopy, McKinley Children's Center, Development Department, 2008.
[49] Ibid.

↑ San Dimas, CA,

By 1915, over 100 boys were in residence at the Industrial Home Society, and they had outgrown their ranch.[50] For several years, they struggled along with too little space for all the boys, the school, the chapel, the dormitories as well as the other buildings and services offered on site.[51] Finally, after the end of World War I, a new 200-acre site was acquired in Van Nuys, California. By 1923, the new site was ready and about 250 boys moved in.[52]

The home functioned for 38 years in Van Nuys, during which time the name changed to McKinley Children's Center, in honor of President William McKinley. Nevertheless, after World War II less than 30 acres of the original 200 remained. New housing demands and freeways cut through the property. It was time to move again. In San Dimas, at the far eastern edge of Los Angeles County, a new site was purchased.

In 1961, ninety-six boys took up residence in the cottages of McKinley Children's Center.[53] The cottages were again signs of the times. The push for more homelike settings was prevalent in the residential care field, and McKinley constructed its new campus and program with that in mind. McKinley occupies this same site today.

By the mid 1980s, McKinley had received a psychiatric rating from the State of California.[54] The boys now in residence at MCC suffered from abject abuse often expressed through psychological illness, rather than simply poverty and neglect.

Although MCC had always considered education to be an essential part of treatment, it was not until 1992 that the agency had on-site its own non-public school, Canyon View.[55] For the previous twenty years, MCC's school had been operated by the Los Angeles County School

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[50] Beltran, 2008.
[51] Ibid.
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid.

System.[56] The MCC staff and board of directors had decided that treatment and education had to go hand in hand, which was not congruent with the views of the LA county school system. The MCC's on-campus public school staff began to work directly with the residential staff to provide a cohesive, holistic model of education and treatment for each boy. This emphasis on healing and teaching the whole boy continues today.

The year 2008 finds MCC still serving children in a multitude of ways, yet never diverging from MCC's original mission statement, which is, "To help troubled children gain the skills, knowledge and self-esteem essential to personal maturity and successful family functioning."[57] Although the means by which to accomplish this goal have changed over the years, the passion behind the words has not.

Currently, MCC provides services to over 500 children and in some cases to their families. More than one hundred of these children attend Canyon View, the on-campus private school. The foster family section of MCC serves over 400 children and some 300 foster families every day, while the outpatient mental health clinic serves between 90 and 125 children and their families on a weekly basis. The residential program has remained a constant since the 1900 inception date and continues to house and provide treatment for between 60 and 66 boys each day.

Demographically the boys and young men who live at MCC are not extremely different than the residents were 108 years ago. MCC serves boys and young men between the ages of six and eighteen, with the densest percentage of boys being eleven through fourteen. The ethnicity has changed a bit since the early 1900s, but today remains constant with 40% of the children

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[56] Beltran, 2008.
[57] Ibid.

being African American, 40% being Hispanic, and 18% being Caucasian, while the remaining 2% is comprised of Native Americans, Asians, and other ethnicities.

Another area of great change over the years is the family or caregiver status. In the early years of MCC, boys often came for a short stay usually due in most part to family finances or the death of a parent. Today, while poverty still plays a role in the lives of the boys who live at MCC, it is seldom the reason for their placement. More often than not, the boys who live at MCC are there because of some type of violence, abuse, and neglect, and often all three. The majority of the children living at MCC have no contact with their parents and limited contact with any member of their biological families. Often this is because the courts have found it unsafe for the children to interact with their biological families.

The Department of Children and Family Services of Los Angeles and the Department of Mental Health of Los Angeles are the primary referral sources for placement of children at MCC. Los Angeles County Probation also refers boys to MCC in an effort to stabilize the boy before returning him home. Occasionally a local school district, through the funding source of AB3632, will place a boy at MCC. Other county children's services or mental health agencies, like those of San Bernardino, Riverside, and Ventura counties, place boys at MCC if they cannot find suitable placement within their own counties. There is an extreme shortage of beds at facilities that provide on-site physical and mental health services for the kinds of boys MCC serves. Even fewer offer any type of spiritual care.

Though the boys at MCC are typically referred to as victims either of their parents' or caregivers' abuse and/or of neglect, as is often the case in trauma-related situations, mental health problems arise. The majority of the boys at MCC have been given DSM-IV diagnoses by at least one mental health professional along the way. These diagnoses range anywhere from

adjustment or anxiety disorder to major mental illness, such as post traumatic stress disorder, major depression, bipolar disorder, even schizophrenia, all of which have symptoms that are exacerbated by trauma and stress.

MCC provides mental health services, including individual and group therapeutic and case management services to the boys residing there, as well as to their families, if possible. Furthermore, the boys who live on campus receive dental care and psychiatric and pediatric services. Most of the boys who reside at MCC attend the on-campus school and are invited to participate in the after-school sporting program. There is also an ongoing after-school and weekend activity program for the boys who live on campus. The boys attend local amusement parks, professional sporting events, theater performances, and go to the beach on a regular basis. They are also offered tennis, golf, and cooking lessons, along with the on-campus softball games, international day celebrations, cookouts, and ice cream socials, which sometimes include the girls from the neighboring girls-only residential facility.

Over the course of a century, MCC has provided service to more than 15,000 boys and as often as possible to their families as well. However, the current staff and board of directors of MCC desire to offer more: they desperately want to offer a program rich in spiritual care for the boys who reside on campus, for their families, and for the community at large.

Few of the boys enter MCC with any self-soothing capabilities, and so their symptoms often escalate as a result. The self-soothing techniques most children use, including family, friends, community support, and religion, are most often absent among MCC boys. Although a sizeable number of the boys (80%) come into MCC asserting some sort of spiritual belief or at least awareness, very few have any type of spiritual or religious connection that appears to provide support or soothing.

Spiritual care or support is not often part of the programmed activities of residential or mental health facilities, as we shall see in the next chapter. However, across its rich history, MCC has consistently sought to provide some type of spiritual care opportunities. It is to this notion of what such a spiritual care program might look like that we turn in the next chapter.

Chapter 2

Review of Spiritual Care in Selected Residential Settings

Spiritual care programs in government-funded residential facilities are limited in scope and availability. Such programs typically include components such as worship services, along with additional groups each week focused on spiritual and/or religious themes that are expressed through music, sacred text study, and meditation exercises. All such components are created to provide a non-sectarian, age-appropriate, spiritually-rich healing environment. While there are several residential facilities throughout southern California, there are only two comparable residential facilities within a 25-mile radius of MCC. By comparable, I mean that each area in southern California functions within a certain cultural context; hence, the county of Los Angeles is divided up into 7 service provider areas (SPAS). These SPAS each have programmatic and contractual requirements based on the demographics of that SPA. This can translate into very different program components for a child in a residential facility in SPA 1 compared to a child in SPA 6. The facilities of Leroy Haynes Center and David and Margaret Youth and Family Services share SPA 3 with MCC, which makes them the most comparable because they are bound by the same requirements and components for residential care as set forth by Los Angeles County.

Leroy Haynes Center (LHC) is a 72-bed, male-only, residential facility less than 10 miles from MCC. LHC employees do not offer any type of overt spiritual care on their campus, nor do they officially recognize the need for any.

On the other hand, David and Margaret (D&M), which is a 60-bed, female-only residential facility less than five miles from MCC, offers spiritual care, albeit in a limited way.

D&M has an on-campus part-time chaplain, when funding allows, and a small spiritual care program consisting of chaplain visits to residents and to staff, if time allows. This organization acknowledges the need for spiritual care and has a deep desire to increase its spiritual care program when funding is available.

Yet the reality is that when funding is available to residential facilities, it is often only available within certain parameters. This is the case with Boys Town, which is a national nonprofit child welfare agency that is church-funded and has a residential component. It has a rich and full spiritual care program, but it is strictly Christian-based. This strictly Christian focus necessitates private funding, which they have. According to the U.S. Constitution, the government cannot provide funding for a program that in any way mixes church and state. Hence, any program or agency that has a strict adherence to a single religious or spiritual tradition cannot be funded through governmental dollars. However, if a child asks to worship according to a particular tradition, that child's request must be met. Therefore, governmentally funded agencies or programs can provide spiritual care only if it is request-driven or nonsectarian in nature.

I briefly outline the Boys Town residential program in the following paragraphs because the program does offer exceptional spiritual care from a Christian perspective. This model makes some basic assumptions that can be applied across theological and spiritual lines, and it offers a structure for spiritual care in similar contexts that has great merit, wisdom, and insight.

The majority of the core assumptions of the Boys Town model spring from a quotation from Father Val Peter, the first executive director of Father Flanagan's Boys Home, which would become the cornerstone for today's Boys Town. Father Peter stated, "At the root of all abuse in

the lives of at-risk kids is a spiritual illness.[58] He suggests that this spiritual illness is played out in three distinct ways in the lives of these children: their sense of powerlessness; the choices they make; the challenge of living in a consumer society.[59] Central to these three manifestations of spiritual illness are the following assumptions:

1. Through abusive acts, children feel powerless, unable to be or to feel in touch with God (Higher Power) in their lives.
2. Without a sense of right and wrong, a child does not possess a road map for life, but the child can acquire this ability to discern between right and wrong through the Christian Scriptures. These scriptures provide the road map and give the child a starting point and an ultimate destination in life, which is described as union with God through Christ.
3. Without this road map a child does not have the directions he or she needs to make positive choices about how to live. Whether or not he/she accepts the way to find a relationship with God is up to each child. Through this relationship, the child can make positive choices or the child can choose to turn away. If the child turns away, then that child will have no real sense of destination or the ability to make positive choices.
4. Therefore, thanks to a relationship with a Higher Power, at risk-youth do have the chance to exercise limited power, to make positive decisions about how to live, and to address the ongoing challenges of living in a consumer-oriented society.
5. Spirituality as defined by the Boys Town model therefore invites children to meet God, and without this pathway or map of spirituality, the child cannot discern how to encounter God.[60]

These assumptions form the foundation for the philosophy and structure of the Boys Town spiritual care programs.

The Boys Town model was developed through a research grant from the Religion Department of the Lilly Endowment. Out of this research, emerged ideas about what the spiritual needs were of the at-risk children that Boys Town served and how best to meet those needs. In this chapter, I describe only the basic tenets of the Boys Town model, since governmental funding would not cover similar spiritual care at MCC.

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[58] Everson, 1.
[59] Ibid.
[60] Ibid., 1-3.

The Boys Town model addresses both the spiritual and moral life of the at-risk children through reviewing such variables as the child's self-esteem, interests, abilities, religiosity, worries, drug use, stealing, lying, and physical violence expressed through fighting. In addition, it assesses the child's pornography use, premarital sexual activity, and suicidal thoughts, and evaluates the child's prosocial behaviors.

Boys Town found that a child's level of self-esteem affected both their positive and negative behaviors, and that self-esteem could best be fostered through four factors: connectiveness, power, uniqueness, and models. Therefore, they built a program with six components to address all four of these factors.

The program mandates attendance at 12-step programs, scripture studies and prayer meetings, service programs, retreats, worship participation, and religious education programs. Each program component deliberately includes techniques and strategies for engaging the child, such as the use of art, music, movies, television shows, and multimedia presentations. Among these are writing in journals, drama, role-playing, using concrete symbols that can be touched and felt, as well as singing and story telling. The program includes teaching faith skills such as how to pray, how to participate in worship, and how to study the Bible, since these all appear to enhance self-esteem.

The Boys Town model presented in the Pathways Training Program is a rich and comprehensive guide to creating and implementing a spiritual care program in a residential facility for at-risk children. A limitation is that the model's strict adherence to Christian religious ideology makes it difficult to generalize its practices and learning to government-funded programs.

Unfortunately, the constitutionally-mandated separation of church and state creates an almost insurmountable barrier to providing spiritual care in government-funded programs. However, Reverend Michael Friesen addresses this issue in chapter nine of his book, *Spiritual Care for Children Living in Specialized Settings: Breathing Underwater*. He believes that the "First Amendment obligates us to provide access for the religious and spiritual needs of children who come to us" in much the same way that the U.S. military provides chaplains, chapels, and religious services to military personnel when they are away from their home communities.[61] Given the fact that most children in residential facilities are removed from their homes by the courts or local governmental agencies, Friesen suggests that the same rules apply to these children as to the military personnel when they are taken away from their home communities. The First Amendment would then allow these children to be provided with the religious or spiritual teachings of their choice or the spiritual care program at St. Joseph's and MCC would be restricting the religious freedoms.[62]

Though Friesen's reasoning appears sound, most residential facilities do not want to take the chance of jeopardizing their government funding sources , which would force them to close their doors. Therefore, they opt not to provide such spiritual services for their clients.

Friesen understood this valid fear when he constructed his spiritual care program, although his spiritual care program was funded, designed, and implemented within a religious tradition and thus exempt from the constraints of governmental funding. Friesen was the Director of Pastoral Care at St. Joseph's Home for Children, which was funded by the Catholic Church. Yet, even though the Catholic Church provided the funding for St. Joseph's Home and thus was not obliged by governmental funding to provide an ecumenically-based spiritual care

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[61] Friesen, 96.
[62] Ibid.

program, Friesen, with the support of the Catholic Church, chose to support the creation of one anyway. The Catholic Church allowed this program a greater breadth and embraced a non-sectarian, ecumenical theological stance, quite different from the Boys Town model. With this in mind, Friesen's model seems to provide a basic framework to begin building a spiritual care program for MCC. Hence, a review of Friesen's model follows.

Friesen's model shares some basic assumptions and philosophical underpinnings with the Boys Town model. For example, Father Peter, of Boy's Town, postulated that spiritual illness is the root cause of all the abuse that occurs in the lives of at-risk kids.[63] This is very similar to Friesen's contention that "the children who come to specialized care are suffering, which is a spiritual condition."[64] Friesen goes on to say that "often for children in specialized settings, their spiritual journey has been harmed or distorted because of the suffering they have experienced; the chaos in their lives proceeds to cut them off from the spiritual resources."[65] This echoes Father Peter's observation that "through abusive acts, children feel powerless, unable to be or to feel in touch with God."[66] Therefore, some of the basic assumptions of the two programs mirror each other, but the core beliefs and theological underpinnings differ, with Friesen's model being more ecumenical and the Boys Town model being intentionally and distinctly Catholic in focus.

Friesen distinguishes between religion and spirituality; he suggests that, "spirituality accentuates the personal faith journey while religion emphasizes the collective journey of faith that binds and supports a community."[67] He emphasizes the need for individual spiritual journeys among institutionalized children when he says that "the children who come to us are in

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[63] Everson, 1.
[64] Friesen, 15.
[65] Ibid.
[66] Everson, 1.
[67] Friesen, 13.

the midst of a profound spiritual experience…a very holy and sacred time in their lives."[68] Given the fact that the people who spend the most time with these children are the staff who are with them in their cottages, it is not hard to understand why Friesen suggests that each individual staff member, not only the chaplain, can have a profound effect on the spiritual lives of these children. Staff members enter into the children's holy, sacred, spiritual journey by being fully present to the child. Friesen states "spirituality by its nature is a relational experience" and spiritual healing happens in the midst of relationship, which is why he believes all the staff in residential care facilities, from the gardener to the CEO, are in some sense potential spiritual care providers.[69] Friesen's model reflects these core beliefs.[70]

Friesen's model is focused on the idea of ministry of presence in action. Key to his model is good preparation, both for the agency as a whole and for individual staff members. Friesen advocates for four stages in preparing to implement his model. The first two stages are information gathering and decision evoking. These stages clarify the current situation, then move on to identifying the key people in the organization who can influence and support the spiritual care program.[71] The next stage emphasizes the decision to change, and the final stage offers principles for implementing and developing the program.[72] It is a lengthy and somewhat arduous task, a reminder of the importance of a spiritual program not only for the organization but also for each individual child. Friesen believes "a design for spiritual care is an ongoing process of listening and responding to the spiritual needs of the children in our midst" and thus

Spiritual Care,

[68] Friesen, 14.
[69] Ibid., 13-20.
[70] Friesen, telephone conversation with author, March 7, 2008.
[71] Friesen, 13.
[72] Ibid., 108-111.

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"it is not something reserved for religious professionals, it is as natural and necessary as the air we breathe."[73]

After the preparation stages, implementation begins. St. Joseph's Home for Children, where Friesen developed and implemented this program, had an actual spiritual care department. This department served about 150 children with two part-time chaplains and a full-time director who also served as a chaplain.[74] There are two areas in which most of the children live at St. Joseph's, and the two part-time chaplains each have primary responsibility for one of those areas. The director floats between areas and directs the Monday through Thursday evening spiritual care groups. He also facilitates the Sunday evening chapel services.

The Monday through Thursday evening groups have various themes. For example, the Monday night group is a generic choir group. However, the Tuesday night group, a Native American drums and dance group, addresses some specific cultural spiritual needs of some of the children that live there, as does the Wednesday night Native American talking group and Bible study. Thursday evening is Thursday Nite Live, an interactive, comedy-based group that focuses on both cultural and current issues from a spiritual perspective.

Many children are off campus on the weekend, so on Fridays and Saturdays the spiritual care staff focuses on maintaining visibility on campus. Often on Fridays and Saturdays, the spiritual care staff makes several individual spiritual care calls to children and staff. This is an excellent time to interact with the staff due to the lower number of children on campus.

By Sunday, the children return to St. Joseph's after a weekend away. It is very important for the chaplains and the director to be on campus for the children during this time and other transitional times, such as when they return to St. Joseph's from a day at school, and particularly

Spiritual Care,

[73] Friesen, 15, 20.
[74] Friesen, email from author, August 11, 2008.

at bedtime. Judging by the increased negative acting-out behaviors expressed during these times, the children seem to have a particularly high need for spiritual comfort during these transitions.

The spiritual care staff at St. Joseph's instituted a "Rites of Passage" program that celebrates special occasions for the children such as birthdays, or the loss of the first lost tooth, or when a boy's voice changes. Along with the "rites of passage" celebrations, other holidays and special occasions are celebrated, often with some teaching about that particular holiday. This includes teachings about the preparation needed for the celebrations such as decorating, cooking, or fasting. The holiday celebrations are campus-wide and provide an opportunity to build on-campus and community unity.

The larger community is also engaged with St. Joseph's through these celebrations and outreach from the spiritual care department. The spiritual care department gives talks and workshops at local churches or civic organizations. The spiritual care department also began a project called "Project Aware," which invites the local community onto the St. Joseph's campus to visit and tour as a means of raising awareness of the children's needs. In a recent telephone conversation with Friesen he said, "spiritual care is all about the relationship and creating a sacred space where the craft of being intentional and present can be practiced."[75] He believes that by including the larger community in the spiritual care program of St. Joseph's, the relationships he is trying to create can be extended, thus allowing for a larger sacred space for the children to explore.[76]

With this brief look at spiritual care programs offered in residential settings for children, it becomes clear that more not only needs to be done but can be done at MCC. Having reviewed the program offered in the Boys Town spiritual care model and Friesen's spiritual care model, I

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[75] Friesen, telephone conversation with author, March 7, 2008.
[76] Ibid.

found components of each that seem promising for MCC yet the overriding question of how any of these models will help the boys living at MCC remains. The next chapter seeks to address that question.

Chapter 3

Theoretical Resources in Trauma Theory, Attachment Theory, and Spiritual Care

This chapter develops a theoretical framework for showing how a spiritual care program addressing the attachment needs of traumatized children can help decrease these children's need to act out in negative and often self-destructive ways. I first review the basic ideas and intersections of both trauma and attachment theory, and then explore how pastoral care and counseling can address spiritual trauma. I conclude by discussing how the implementation of a spiritual care program can promote healing within all three of these arenas, and how this ultimately helps reduce the destructive impact of trauma and increase the healing possibilities of attachments.

Trauma and attachment theory have long been connected with a presumed attachment deficit resulting from the trauma. Judith Herman, in her book *Trauma and Recovery,* states that "traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning."[77] She also suggests "traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of self and the meaningful order of creation."[78]

Dalene Fuller Rogers connects the effects of trauma not only with the loss of the meaningfulness of creation but also with several other spiritual losses. These include losing a sense of awe and wonder at creation, a disavowal of the goodness of humanity, and an overall loss of faith in God,[79] the latter being an effect of trauma that Jon Allen also mentions.[80] Several

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[77] Herman, 51.
[78] Ibid.
[79] Dalene Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder: Healing the Shattered Soul* (~~Binghamton: The~~ Haworth Pastoral Press, 2002), 19.

authors echo this, claiming trauma as a catalyst for alterations or losses of meaning in spiritual things,[81] including the loss of faith, of safety, and of the basic ability to trust.[82]

These losses of faith, safety, and trust are just the tip of the trauma iceberg. Trauma metaphorically crushes the traumatized person's world in a multitude of ways resulting in cynicism, bitterness, alienation, hatred, vengefulness, demoralization, and loss of hope.[83] Some additional primary symptoms of trauma including hyper-vigilance, flashbacks, hyperactivity, jumpiness, intrusive thoughts, and depersonalization all work together to create an inability to self-soothe or attach.[84] Briere and Scott also note the symptom of disassociation, which is often described as a hallmark symptom of trauma.[85] The DSM-IV categorizes this cluster of symptoms as being potentially diagnosable as posttraumatic stress disorder or PTSD. The diagnostic criteria for PTSD according to the DSM-VI are found in Appendix One.

Yet according to Judith Herman, the diagnosis of PTSD does not adequately describe what happens to many trauma survivors. She suggests that the cluster of symptoms she refers to as "complex PTSD" presents a more complete picture.[86] Several other authors and trauma experts agree that PTSD is not an adequate or complete diagnosis, so much so that one author goes beyond the categories of PTSD and divides trauma into six different areas.

These six areas according to Jon Allen include: single blow vs. repeated trauma; interpersonal trauma; objective vs. subjective trauma; developmental trauma; attachment trauma;

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[80] Jon G. Allen, *Coping with Trauma: Hope Through Understanding* (~~Arlington:~~ American Psychiatric Publishing, ~~Inc.~~, 2005), 13.) Washington, DC!

[81] Mary Beth Williams and Soili Poijula, *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms* (Oakland: New Harbinger Publications, ~~Inc.~~, ~~2000~~), 12.

[82] Herman, 51-52. ↑CA 2002

[83] Allen, 5.

[84] Ibid.

[85] John Briere and Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment* (Thousand Oaks: Sage Publications, ~~Inc.~~, 2006), 25-27.

[86] Herman, 120. ↑CA

and, finally, spiritual trauma.[87] Allen defines "spiritual" as a sense of connection with something vast or grand, beyond the self, a connection which involves love, trust, reverence and wisdom.[88] Thus spiritual trauma, according to Allen, is seen as experiences that result in an inability to trust or form any type of attachment relationship.[89] Hence, without the ability to trust or form relationships the possibility of acquiring faith is undermined and can culminate in a loss of hope for any type of spiritual connection, thus spiritual trauma.[90]

Each of the six areas of trauma has a multitude of sub-areas that affect the traumatized victim. For example, single vs. repeated trauma, according to Allen, often considerably alters the devastation the trauma causes.[91] Single events of trauma are less likely to create long-term devastation, while "the traumatic experiences that result in the most serious psychiatric disorders are prolonged and repeated."[92] This supports the idea that traumatic effects can be cumulative and a set up for repeated traumatization.[93] Several authors and experts agree with the suggestion that traumatic experiences not only have a cumulative effect but also predispose a person to re-victimization.[94] One might say that trauma is contagious.[95]

The concept of trauma as contagious seems to combine the second and third arenas of trauma. While interpersonal trauma can occur within an endless variety of events, the impact of that event and the trauma either sustained from it or not, can be viewed through either an objective or subjective lens and the results of this can become contagious. Hence, for example, an objective witness to an automobile collision can report without hesitation that a car ran

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[87] Allen, 5-41.
[88] Allen, 285.
[89] Ibid., 5-13.
[90] Ibid., 13.
[91] Ibid., 5-41.
[92] Ibid, 6.
[93] Allen, 6; Briere and Scott, 10.
[94] Ibid.
[95] Briere and Scott, 10.

through the stop sign into a tree. However, the a subjective witness will lament the trauma incurred by the driver of the car based on the look of anguish and alarm on the driver's face as he or she drove through the stop sign. The objective witness does not assign trauma while the subjective witness experiences trauma by creating it and then passing it along to others. Trauma is subjective or experienced on an individual basis. Better stated, "the subjective experience of the objective events constitutes the trauma."[96]

Many factors contribute to the subjective internalizing of an event as trauma. For example, the age of the person experiencing the event is of critical importance; the younger the victim, the greater the chance that an event is experienced as traumatic and will have longer-lasting physical, psychological, and even academic consequences. Furthermore, the younger the victim, the more likely he or she is to be re-victimized.[97]

Age is not the only factor that contributes to an event being perceived as traumatic. One author describes three specific categories of factors that influence how an event will be experienced. The categories are pre-event factors, event factors, and post-event factors.[98] The pre-event factors include age but go beyond that to include previous exposure to trauma or adverse life events, and earlier mental health illness such as depression or anxiety, which has affected brain chemistry.[99] Gender is also a factor, with women being twice as likely as men to experience an event as being traumatic, and thus more likely to develop PTSD at some point in their lives.[100] Race and socioeconomic status also seem to contribute to the traumatic effect of events.[101] However, the higher rates of PTSD for women and ethnic minorities do not appear to

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[96] Allen, 21.
[97] Victoria M. Follette and Josef I. Ruek, eds., *Cognitive-Behavioral Therapies for Trauma* (New York: The Guilford Press, 2006), 406.
[98] Williams and Poijula, 4-6.
[99] Williams and Poijula, 5.
[100] Ibid.
[101] Ibid.

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be due to a decreased ability to handle stress, but rather to increased and more frequent exposure to traumatic events than their male or majority counterparts.[102] People of lower socioeconomic status are also more likely to experience an event as traumatic as people of a higher socioeconomic status.[103] African Americans and Hispanics are more likely to be traumatized than Caucasians.[104] Again the higher occurrence of traumatic exposure in the lower socioeconomic and minority communities may account for the greater likelihood of internalized trauma. Genetics are important to understanding the effects of trauma as some families withstand trauma better than others do, which may be connected to the effectiveness of their coping skills and the presence of or lack of a dependable support system.[105] These are just a few of the numerous pre-event factors that can contribute to an event being experienced as traumatic.

Event factors, which influence the traumatization of an event, are often a bit more concrete. For example, one's geographic proximity to the event can influence how traumatically one experiences the event, as do the level and length of the exposure to the event.[106] The ongoing existence of a threat or potentially traumatic event increases the possibilities for longterm harm as does the level of voluntary or coerced participation in the event.[107]

Finally, the post-event factors that weigh most heavily on the possibility of an event being interpreted as traumatic include the immediate responses to the trauma and how these responses are managed. For example, after the traumatic event, having a good support system available with which to process the event lessens the likelihood of the event being perceived as traumatic, while the absence of such a support system increases the likelihood of

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[102] Breire and Scott, 15.
[103] Ibid., 14.
[104] Ibid.
[105] Williams and Poijula, 5.
[106] Ibid.
[107] Ibid., 5-6.

traumatization.[108] If there is a possibility of being able to do something about the event or of finding meaning in the occurrence of the event, then the potential for traumatization is reduced. However, if no meaningful explanation can be found for the event and the person slips into self-pity or despair without the help of a support system, the event becomes not only traumatic but a catalyst for greater illness and harm, such as acute stress disorder or post traumatic stress disorder.[109] These are just a few examples of factors that might influence the traumatic potential of an event for an individual.

Regardless of why or how the event has occurred and been viewed, once trauma is internalized, it has a developmental impact. Traumatic events violate the autonomy of the person, thus preventing a resolution to the normal developmental conflict involving autonomy, which leaves a person prone to shame and doubt.[110] This delay compounds itself by creating potentials for delays in other developmental stages. For example, in the aftermath of a traumatic event, many survivors experience feelings of guilt and inferiority, as well as residual shame and doubt. This addition of guilt and inferiority further delays the progress of development by leaving the survivor convinced that he or she is incompetent.[111]Additionally, depending on the many variables of the trauma and when in a person's development it occurred, a person can end up viewing him or herself as inadequate, bad, and helpless, thus potentially seeing the future as hopeless.[112] In a snowball effect, one developmental stage after another is affected. Simply stated, trauma derails development.[113]

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[108] Williams and Poijula, 6.
[109] Ibid., 6.
[110] Herman, 52.
[111] Ibid., 53.
[112] Breire and Scott, 77.
[113] Allen, 19.

With attachment being a developmental process and development derailed through traumatic events, the concept of attachment trauma becomes evident. Attachment trauma is so complex and important that I discuss it separately in the next section, and then explore spiritual trauma through the discipline of pastoral care and counseling. More explicitly, as Dalene Fuller Rogers suggests, "all forms of trauma … have an effect on one's spirituality."[114]

Ultimately, however, the most helpful way to define trauma is by its effect on a particular person and that individual's responses.[115] Thus far I have been discussing trauma in a general and objective sense, but for the purpose of this project the symptoms of trauma and the reality behind trauma theory have to be described in a much more specific and child-centered way. Although some trauma symptoms can be similar for both children and adults, according to Levine and Kline, "all children…show symptoms (of trauma) that are distinctively different from those of adults."[116] Perhaps this is due in part to the fact that often adults have better self-soothing capabilities and greater access to outside resources for help than children do. Hence, often adults have the ability to move on past the trauma, while children who experience trauma stay "stuck" in their trauma.[117]

More often than not, these children continue to act in some ways as if the trauma were still occurring. For example, often their bodies are on continuous alert and they have an ongoing sense of being overwhelmed.[118] Yet these effects frequently occur subconsciously, with the child often being overwhelmed with shame, shattered by betrayal, and bound by secrecy.[119]

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[114] Rogers, 8.
[115] Peter A. Levine and Maggie Kline, *Trauma Through a Child's Eyes: Awakening the Ordinary Miracle of Healing* (Berkeley: North Atlantic Books, 2007), 37.
[116] Ibid., 40.
[117] Ibid., 21.
[118] Ibid., 20-21.
[119] Ibid., 27.

These children do not have the ability to self-soothe or create an internal sense of calm. The inability to self-soothe is just one of the ways in which traumatic occurrences impact children.

Children have a very limited available repertoire of responses to a traumatic event, and the younger the child the smaller the repertoire. For example, very young children, still limited in language and motor skills, often react with increased impulsive behaviors and irritability or by withdrawing.[120] However, their memory of the trauma is often reenacted with extraordinary accuracy in their play.[121] These children let us know that they have been traumatized through their sleep and play patterns as well as by their somatic complaints.[122] Often these children display exaggerated emotional responses and regress to earlier developmentally appropriate responses, with attainment of normal developmental milestones being delayed.[123] For example, when elementary age children exhibit clinging behaviors or tantruming, developmental delays are more obvious as these behaviors are typical for children of a much younger age.[124]

Furthermore, when these school-age children, roughly 5 to 11 years old, seem particularly worried, or are having repeated sleep disturbances, or seem to be suffering from numerous somatic complaints, the possibility of trauma exposure should be investigated.[125] In school, these children manifest their symptoms in clearly observable ways. Often these children appear fidgety and hypervigilant.[126] They have a quick startle reflex, are easily distracted, and find it hard to concentrate.[127] Gender differences regarding symptomology often occur within this age range, with boys often externalizing their trauma symptoms by hitting, bullying, teasing,

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[120] Levine and Kline, 43.
[121] Herman, 38.
[122] Levine and Kline, 43.
[123] Ibid.
[124] Ibid., 50.
[125] Ibid., 55.
[126] Ibid., 57.
[127] Ibid.

and engaging in "daredevil" activities and girls by often withdrawing and isolating themselves, appearing fatigued or as if they are engaged in daydreaming or fantasies.[128]

Adolescents display symptoms much more closely aligned to those of adults. The gender differences first observed at younger ages are still relevant, with boys more likely to show a correlation between their externalizing behavior and substance abuse than the girls.[129] The girls are now more likely to move from internalizing to more externalizing symptoms of trauma. For example, the girls may become more defiant and irritable rather than depressed or withdrawn.[130] Both boys and girls continue to exhibit the hypervigilance and hyperarousal that is observed in younger children, as well as appearing clingy, with a lack of motivation, and an inability to initiate activities.[131] Many times these symptoms are misdiagnosed as being, attention deficit with hyperactivity or bipolar disorder.

All of these symptoms can not only be misdiagnosed but can and do also interfere in normal developmental movement. In infancy, the basic ability to trust is violated, hence disturbing the developmental task of that period. School-age children are often so impaired they cannot find a sense of industry or initiative, which renders them incapable of accomplishing the developmental tasks that are required. Judith Herman comments that "traumatic events, by definition, thwart initiative and overwhelm individual competence."[132] Furthermore, in adolescence, the task of identity and autonomy must be accomplished. Unsatisfactory resolution of the normal developmental conflicts over autonomy leaves the person prone to shame and doubt, according to Judith Herman.[133] Finally, the developmental task of identity cannot be

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[128] Levine and Kline, 57-60.
[129] Ibid., 61.
[130] Ibid.
[131] Ibid., 66.
[132] Herman, 53.
[133] Ibid.

established for a child who has not passed through the previous developmental stages nor been given any type of attachment figure from which to gain a sense of self-worth. Without those, the task of establishing an identity is simply impossible. Hence, attachment is the cornerstone of development.

Attachment Theory

In this section, I present a brief review of the history, and the basic tenets of attachment theory. This review includes the three most commonly accepted attachment styles, and how they each, in turn, can affect development. Through this discussion the symptomology of the various attachment styles and the related developmental issues for the boys served at MCC will become evident, as will the impact of their traumas.

Attachment theory was born over sixty years ago in British psychoanalytical circles, with John Bowlby declared as its father.[134] The theory has gone through much transformation since then, including maturation in the developmental psychology departments of American universities. The theory has blossomed in all directions, as we will see, yet at the center of it all, according to Robert Karen, "it is a theory of love and its central place in the human life."[135] However, John Bowlby, using less impassioned words said, "the theory of attachment is an attempt to explain both attachment behavior, with its episodic appearance and disappearance and also the enduring attachments that children and the other individuals make to each other."[136] Thus, according to Bowlby, "our lives from cradle to grave revolve around intimate attachments."[137]

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[134] David J. Wallin, *Attachment in Psychotherapy* (New York: The Guilford Press, 2007), 11.
[135] Robert Karen, *Becoming Attached: First Relationships and How They Shape Our Capacity to Love* (New York: Oxford University Press, 1998), 3.
[136] John Bowlby, *A Secure Base: Clinical Applications of Attachment Theory* (London: Routledge, 1988), 29.
[137] Wallin, 1.

Although Anna Freud, one of the matriarchs of the psychoanalytical world, initially followed her father's lead by claiming the mother-child bond was due to the child's need for nourishment, she eventually chose to walk somewhat nearer to John Bowlby's views.[138] She began as a quiet observer until she voiced her support of Bowlby's views on attachment and mother deprivation by stating that the "loving attachment to mother was ultimately more important to psychological development than the instinctual repression her father had emphasized."[139] The quiet was broken and the psychoanalytic world heard and took notice. That notice, however, was not widely supportive. John Bowlby was not surprised; he had grown used to this systematic dismissal of his ideas by the psychoanalytical world.

Already in the late 1930s he had begun an embattled discussion on the developmental harm a child typically suffers as a result of maternal deprivation. He fought against his entire cohort in the psychoanalytical world as well as pediatricians and nurses across the globe.

John Bowlby began his career in medical school, although he did not want to follow in the footsteps of his father, who was a surgeon to the King of England.[140] So when, in his third year of study at Cambridge, he read psychology and was "intrigued" and "decided to take it up – whatever that meant," it was no surprise.[141] John Bowlby had the perfect personal family experience to propel him into the study of childhood attachment.

His was a conventional upper-class British family in which intellectual rigor and a "stiff upper lip approach to all things emotional" was the norm.[142] John Bowlby was the fourth child in a family of six children, three girls and three boys.[143] He was quoted as saying, "mine was a

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[138] Karen, 89.
[139] Ibid., 91-92.
[140] Ibid., .30.
[141] Ibid., 31.
[142] Ibid., 30.
[143] Ibid.

very stable background," but assuming that this meant it was a warm, secure, or emotionally responsive home would be incorrect.[144] Although Bowlby would go on to claim these attributes were some of the most important to have in the home for a child to develop normally and achieve a secure attachment, he never spoke openly about their lack in his childhood home. He did, however, on occasion, speak about how unhappy he was when at age eight he was sent away to boarding school, a family tradition and in those days quite typical of families of his class.

It is no wonder that as an adult, John Bowlby was drawn to the relatively new idea of the British progressive schools. They were also boarding schools, but very unlike the one Bowlby attended. These schools were residential schools for maladjusted children and viewed as well outside the norm by mainstream educators.[145] Nevertheless, here John Bowlby discovered the foundational cornerstone of his views on child development and attachment theory.

A. S. Neill, the founder and director of Summerhill school, the progressive school with which John Bowlby first found himself intrigued, argued that a "disciplinary regime was exactly the opposite of what children needed … it quashed their natural inquisitiveness and stunted their individuality."[146] At this school, the teachers were trained to be "gently available rather than figures of fear and authority."[147] With this awareness, John Bowlby promptly quit medical school and found a progressive school where he could volunteer.

Priory Gate in Norfolk was the school where John Bowlby settled. Here he spent a great deal of time with John Alford, who was another volunteer and a war veteran who had also been through analysis.[148] This was a hugely influential time for Bowlby, as Alford explained the connection between the disturbed behavior he was observing in the children and their

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[144] Karen, 30.
[145] Ibid., 31.
[146] Ibid., 32.
[147] Ibid.
[148] Ibid., 32.

unfortunate early histories.[149] Bowlby would later say," everything stemmed from that six months" while he was at Priory Gate.[150] It was Alford who convinced Bowlby to return to medical school, this time to study psychiatry and psychoanalysis.[151]

Bowlby completed medical school, joined the British Psycho-Analytic Society, again at the urgings of Alford, and began his work in psychiatry and psychoanalysis.[152] He went to work in the Canonbury Clinic, where he did a study on 44 juvenile thieves and 44 other children who had not stolen.[153] Through this study, Bowlby believed he found a "cause and effect relationship between early deprivations and the criminal character."[154] Although there were many early deprivations in the history of the 44 thieves, there was one environmental factor that Bowlby was able to easily document and that was not open to misinterpretation.[155] This factor was a prolonged early separation of mother and child.[156] Furthermore, Bowlby lamented that many of the juvenile boys had no one in their lives who was truly committed to them, which resulted in these children being incapable of sustaining any type of meaningful human relationship.[157] Thus Bowlby proclaimed he saw a cause and effect relationship between early deprivation and criminal character, this according to Bowlby, was viewed as "mad at the time."[158] This was true in part because during this time psychoanalytic thinking was the mainstay, and it focused on behaviors, being motivated by desires to fulfill primal drives. Bowlby's proclamations flew directly in the face of that.

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[149] Karen, 32.
[150] Ibid., 33.
[151] Ibid.
[152] Karen.
[153] Ibid., 5.
[154] Ibid., 50.
[155] Ibid., 52, 53.
[156] Ibid.
[157] David Oppenheim and Douglas F. Goldsmith, *Attachment Theory in Clinical Work with Children* (New York: The Guilford Press, 2007), 91.
[158] Karen, 50.

Bowlby's study was first published in 1944 to little attention, but its republication in 1946 as a monograph, in which the effects of Bowlby's training with a group of army psychologists during the war could be seen, attracted far more attention.[159] Those psychologists had helped turn Bowlby into a research scientist, a role he continued throughout his life and work. The republication of Bowlby's paper, Forty-four Juvenile Thieves: Their Characters and Home-Life helped "inspire a revolution in child psychiatry."[160] Bowlby was asked and agreed to do a study for the World Health Organization in 1950 on homeless children entitled *Maternal Care and Mental Health.*[161] In this study, he described the similarities of symptoms in all the children deprived of their mothers for one reason or another.[162]

The belief that maternal deprivation created ill effects on children had become a common theme not only for Bowlby but for many other child psychiatrists and social workers around the globe. The symptoms associated with maternal deprivation included: an unending hunger for love, which often expressed itself through hostility, rage, depression, or; a perverse lack of interest in affection.[163] These typically culminated in the child's inability to form any type of deep or lasting connection.[164] Bowlby would describe these children as "affectionless" and as having a "remarkable lack of warmth or feeling for anyone."[165] Yet he cautioned that "behind the mask of indifference is a bottomless misery and behind the apparent callousness despair."[166] With these proclamations, Bowlby gained popular approval and became a household name in Great Britain as well as "a champion of childcare workers" across the globe.[167]

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[159] Karen, 57.
[160] Ibid., 58.
[161] Ibid., 59.
[162] Ibid., 60.
[163] Ibid., 47-60.
[164] Ibid.
[165] Ibid., 50, 54.
[166] Ibid., 54.
[167] Ibid., 65.

As Bowlby continued his search for answers to attachment questions, he stumbled upon Konrad Lorenz's work on imprinting.[168] John Bowlby was mesmerized with this idea and became fascinated with the study of ethology. He became convinced that the discoveries of ethologists, such as intergenerational cues, bonding behaviors, and a genetic pre-wiring toward relational experiences, must also apply to humans.[169] He began research on these possibilities.

Along the way, John Bowlby advertised for a research assistant, and Mary Ainsworth answered the call. This was the beginning of a 40-year collaborative journey into the world of attachment theory. Bowlby's ideas provided the starting impetus for Ainsworth's research. The results of her research altered the shape of his thinking and, in turn, created new research and refinements in his theory.[170]

According to Oppenheim and Goldsmith, there are four basic assumptions that convey the essence of Bowlby's conception of attachment relationships.[171] The first assumption is that the intimate bonds people have are biologically based and have a "primary status," followed by the idea that the way a child is treated has a powerful and defining effect on that child's development and personality functioning.[172] Next, it is assumed that the attachment behavior exhibited by the child or adult is part of that person's organizational system that uses an "internal working model" encompassing the self and others, which influences behaviors and expectations.[173] Finally, while this attachment behavior is "resistant to change" there is always potential for change, especially within a loving, nurturing environment.[174] These assumptions were crystallized through Bowlby's work, with added enlightenment from Mary Ainsworth.

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[168] Bowlby, 24-25.
[169] Karen, 89.
[170] Wallin, 9.
[171] Oppenheim, 63. and Goldsmith,
[172] Ibid.
[173] Ibid.
[174] Ibid.

It was, after all, Mary Ainsworth's notion that the child's expectations of and interactions with the caregiver created the child's sense of having a secure base, and this secure base helped "gel in the mental maps or representations that Bowlby dubbed internal working models."[175] The secure base concept is a component of a secure attachment style, which is one of the three attachment styles Mary Ainsworth established with her research.

Mary Ainsworth found three attachment styles through her research. These she dubbed the securely attached and two insecurely attached styles--avoidantly attached and ambivalently attached.[176] She correlated the child's attachment style with several characteristics of the child including the child's character development, schoolwork, problem solving abilities, self-reliance, self-esteem, peer relations, and general sociability.[177]

Ainsworth identified specific behaviors the child exhibited toward his or her mother to identify the attachment style. Furthermore, as the research progressed, she began to recognize a cluster of behaviors for each attachment style even without viewing the child and mother in the strange situation model.

For example, securely attached children appear to have a well-formed internal working model.[178] They also appear to be more advanced in their relationships with others, they smile more often, they are more likely to suggest activities, to be sympathetic, and to be sought out by their peers.[179] This is quite different for the other two attachment styles.

Neither the avoidantly nor the ambivalently attached child has a well-integrated or established internal working model.[180] Internal working models are developed as a roadmap by

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[175] Wallin, 16.
[176] David Howe, *Child Abuse and Neglect: Attachment, Development and Intervention* (New York: Palgrave Macmillan, 2005), 30-37.
[177] Karen, 173.
[178] Ibid., 183.
[179] Ibid.
[180] Howe, 150.

which the child evaluates and responds to interpersonal situations and new environments. The insecurely attached child has not had the opportunity to develop such a model. Instead, these children have formed an unreliable model based on the inconsistent and unreliable care they have been given.[181] Furthermore, the children who display these two styles of attachment struggle with several areas of peer relations. The ambivalently attached child is often too preoccupied with his or her own needs to notice anyone else's feelings, while the avoidantly attached child seems to take pleasure in other children's misery.[182] Often ambivalent children display unpredictable and antagonistic behavior, which creates animosity with the other children.[183] However, the avoidant children seemed to fare even worse. They are widely disliked, and are often considered to have severe disciplinary problems, including being seen as sullen and oppositional, and are frequently viewed as mean.[184] Other behaviors consistently connected with avoidant and ambivalent attachment styles include high levels of reactive aggression, an inability to effectively modulate emotions, and extreme symptoms of attention deficit/hyperactivity.[185]

Ultimately, a lack of a secure attachment between a child and primary caregiver has been positively correlated with such difficulties as failure to thrive, anxiety, depression, low frustration tolerance, poor social skills, social aggressiveness, short attention spans, conduct disorders, and an inability to maintain concentration.[186] Kagan further adds that the more a child experiences rejection and unresolved separations, the greater the child's behavior problems become.[187] Hence, the quest to procure a secure attachment is crucial and paramount.[188]

and Holdsmith,

[181] Oppenheim, 204.
[182] Karen, 185.
[183] Ibid.
[184] Ibid., 187. and Goldsmith,
[185] Oppenheim, 143, & 207.
[186] Richard Kagan, *Rebuilding Attachments with Traumatized Children*, (Binghampton: The Haworth Maltreatment and Trauma Press, 2004), 12.
[187] Kagan, 17.
[188] Bowlby, 46.

↑ which title? Secure Base?

Unfortunately, according to Karen's own clinical experience as well as several studies he cited in his book, attachment styles are widely believed to be consistent across the lifespan, with the loss of early security viewed as an inescapable major cause of emotional distress later in adult life.[189]

However, John Bowlby did not agree that early attachment styles were permanent, although he did believe that both attachment styles and internalized working models were very resistant to change. Bowlby said one of the only remedies for troubled early attachments was a new or substitute secure base, which would create a new attachment style and a new internalized working model, in essence a new way to interact with the world.[190]

The options for the children living at McKinley Children's Center to find such a substitute secure base or attachment figure are minimal. There is rarely opportunity for individual adult-child interactions and the competition for what little time is available is phenomenal. It is for this reason that I think the ministry of presence offered through pastoral care is so critical to these boys, and it is to this that I turn in the next section of the chapter.

Pastoral/ Spiritual Care

This section will begin by reviewing what we have learned about children who suffer trauma and how this may influence their ability to benefit from spiritual care. It will then explain the why and what of the foundational functions used to undergird the spiritual care program at MCC. Finally, a deeper look into the special needs of children in the context of spiritual care will be addressed, culminating in how the MCC spiritual care program seeks to fill these needs.

Thus far, we have learned that children who suffer trauma are often wounded physically, spiritually, and developmentally. For healing to occur, these children have an increased need for attachment that unfortunately is often blocked by their trauma-inflicted wounds that prevent

[189] Karen, 189.
[190] Wallin, 27.

them from trusting. Ultimately, these children act out in ways that push away the few potential attachment relationships that may be available to them and thus re-experience the loss and loneliness of their traumatic histories. Therefore, the ministry of presence, in which a loving, nurturing, human attachment is offered through pastoral/spiritual care, can be life saving. This is especially true and important for the traumatized boys living at MCC.

However, the ministry of presence is only one portion of pastoral/spiritual care and for this project, I will use a much broader vision of pastoral/spiritual care. First, however, I would like to acknowledge, as noted earlier in the Definitions of Major Terms section, and as Paget and McCormack do, that there is a change that has occurred recently in the language used in pastoral care to embrace the growing need for and awareness of religious diversity.[191] In honoring this change of language, pastoral care is now often referred to as spiritual care and throughout this project, I shall use the terms interchangeably.

Over the years many things have changed in pastoral care, not just the name but also, the language used, as well as, the practice of care itself. However, despite some additions to and criticism of their work, the definitions and functions of pastoral care proposed by Clebsch and Jaekle several years ago remain a respected constant in the field. This is why I have chosen to highlight their four functions of pastoral care as the foundation on which to build the spiritual care program for this project.

Clebsch and Jaekle define pastoral care as "the ministry of the cure of souls" which "consists of helping acts, done by representative Christian persons directed toward the healing, sustaining, guiding and reconciling of troubled persons whose troubles are in the context of ultimate meanings and concerns."[192] In the following section, I elaborate on these four pastoral

[191] Paget and McCormack, 18.
[192] Clebsch and Jaekle, 4.

care functions. I shall examine how these four pastoral care functions can intertwine with the needs of the traumatized, attachment-troubled boys of MCC to bring healing.

When healing is mentioned in the context of ministry or pastoral care a plethora of visions can come to mind including physical healing rituals such as the laying on of hands or some other type of physical act in which physical healing is the goal. However, the healing most needed by the boys of MCC is not of the physical nature but more of the spiritual nature. Clebsch and Jaekle define healing as a function that helps a "debilitated person" be restored to wholeness, which includes a greater level of spiritual insight and welfare.[193] Therefore, true healing is much more than mere restoration to a previous state of wellness: it is forward movement culminating in spiritual gain, where a new and greater level of wholeness is achieved. Lartey expounds on this idea by saying that healing involves an awareness of the "transcendent in the midst of life … knowing that this transcendence mediates love, support and help."[194] Wayne Muller so beautifully states that "family pain broke us open and set our hearts on a pilgrimage in search of love and belonging" which "may in fact become the seed that gives birth to our spiritual healing." This is often true for the MCC boys and highlights their need for healing.[195] Healing in the context of spiritual care has much more to do with soul care than physical care.

Jean Stairs says, "there is a noticeable gap in pastoral care and that gap concerns our care for the child's soul."[196] She continues by expressing her belief that "it is exceedingly important to recognize the soul of the child and to affirm and respond to a child's soul-longings."[197] If this is true then the boys at MCC are in desperate need of the healing component of pastoral care for

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[193] Ibid., 8.
[194] Lartey, 63.
[195] Wayne Muller, *Legacy of the Heart: The Spiritual Advantages of a Painful Childhood* (New York: Simon and Schuster, 1993), xiv.
[196] Jean Stairs, *Listening for the Soul: Pastoral Care and Spiritual Direction* (Minneapolis: Fortress Press, 2000), 155.
[197] Ibid., 156.

their very souls have long been neglected and ignored. Perhaps then for these boys to even begin to heal they must experience in their souls the transcendent love of which Lartey speaks. Sadly however, for the boys of MCC, a one-time healing experience of transcendent love will not sustain their healing; most of them have suffered too great a trauma for them to be able to maintain an attachment to such an intangible fleeting occurrence. Hence the need for the sustaining component of the spiritual care program at MCC.

Sustaining, as defined by Clebsch and Jaekle, consists of helping the hurting person to endure or transcend a circumstance in which full healing through restoration is not possible, or highly unlikely.[198] For example, the boys that live at MCC will rarely fully heal from the wounds they received through the traumas that were inflicted upon them. The spiritual wounds of abandonment along with the developmental blocks these boys incurred when one or both of their parents left them will seldom heal completely. Certainly, the wounds may get better, but they will rarely disappear. More than likely, these wounds will leave their marks on these children for the rest of their lives, affecting how they function into adulthood and beyond. Thus, sustaining in this case would mean helping the child find a way to function that would bring him the greatest spiritual wholeness possible within his woundedness.

Yet sustaining goes beyond resignation through employing affirmation and compassionate commiseration.[199] Clebsch and Jaekle assert that sustaining consists primarily of a subset of four tasks: preservation, consolation, consolidation, and redemption.[200] The first task of sustaining is preservation, which holds the person stable without allowing that person to fall deeper into further pain, loss, suffering, or retreat.[201] Preservation is often done through a

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[198] Clebsch and Jaekle, 8-9.
[199] Clebsch and Jaekle, 9.
[200] Ibid., 44-49.
[201] Ibid., 44.

gesture, a word, a glance, a touch, or anything that helps the person hover above that all-encompassing sense of misery that can often be overwhelming.[202] This is where employing ministry of presence in the MCC spiritual care program can be very effective. Consolation is incorporated into sustaining by reminding the person that despite the current pain and suffering, there is some type of hope in the future. Ideally, the spiritual care program at MCC provides this to the boys. Preservation first stops the regressive movement of suffering and consolation seeks ultimately to remove or at least relieve the misery brought on by that regression.[203]

Once the regression has stopped and the misery is being relieved then the next step of sustaining can occur. That task is consolidation. Consolidation seeks to begin the rebuilding process. Within the task of consolidation, suffering is put into the perspective of the totality of life, where loss is seen as an opportunity to rebuild something new.[204] This is the beginning of the final task.

Redemption is the final task of sustaining. In this task the person who has stopped the progression of the pain, embraced the loss, and then begun to regroup, now builds a new life.[205] Lartey states that to be sustained is "to find strength and support from within and without … it has to do with transformation," a transforming of the pain into a new way of living.[206] This new life is not a return to the status quo but a move to greater fulfillment and spiritual growth. Jean Stairs suggests that the healing may begin for children when their souls are recognized and affirmed, but that the sustaining of that healing would require more. She declares that the development of a child's soul is done through reverence.[207] Reverence can be expressed through

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[202] Ibid., 45.
[203] Ibid., 47.
[204] Ibid., 47-48.
[205] Ibid., 48.
[206] Lartey, 64.
[207] Stairs, 156.

respect and validation by listening with sensitivity and delight, not for a moment but ongoing, for a lifetime.[208] All of this is done under the auspices of sustaining, which is preparation for guiding.

According to Clebsch and Jaekle, guiding is "that function of ministry of the soul that arrives at some wisdom concerning what one ought to do when faced with a difficult problem."[209] Within the context of the guiding ministry, it is assumed that wisdom, which will edify and illuminate the meaning and direction of life will be acquired.[210] However, I believe Lartey would be more proactive in the role of guiding and not assume wisdom would be passively acquired. Lartey declares that, "guiding is about enabling people through faith and love, to draw out that which lies within them."[211] Perhaps wisdom is something that lies within but Lartey suggests actively drawing it out versus assuming it will be acquired, which can be done in many ways. For example, the chaplain of the MCC spiritual care program, seeks to draw out "that which lies within" as part of practicing the ministry of presence when she provides opportunities for the boys to be heard by listening.

Listening, advice giving, and help in decision-making are all considered components of guiding.[212] Guiding can also be "leading people to the threshold of their mind" where an expansion of their awareness and a clarification of their personhood can occur according to Lartey.[213] Thus if a boy at MCC is able to reach a stable place where his pain is not continuing to pull him into all the things that cause downward mobility, he may be able to pause and look

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[208] Ibid.
[209] Clebsch and Jaekle, 49.
[210] Ibid., 50.
[211] Lartey, 65.
[212] Clebsch and Jaekle, 50-56.
[213] Lartey, 65.

for direction. When he does this, the function of guiding can actively help move him on to wholeness through the next step of reconciling.

Reconciling, according to Lartey, involves "bringing together again parties that have become estranged or alienated from each other."[214] For the boys of MCC, Lartey's definition of reconciling simply may not be possible; most of these boys have been removed from their parent's home due to various types and degrees of abuse which very often will prohibit them from returning home or reconciling these relationships.

However, Clebsch and Jaekle offer another definition, they define reconciling as a means to help alienated people establish or renew proper and fruitful relationships with God and their neighbors.[215] This definition may prove more viable to the boys of MCC because many of them come to MCC alienated from God for various reasons, one of which may be the acquired religious beliefs they have brought with them that have filled them with shame and fear. Thus, oftentimes the reconciliation which some of the boys of MCC have expressed is with God. Certainly, there are many ways to do this; Clebsch and Jaekle suggest two modes of reconciliation, which are forgiveness and discipline.[216] Forgiveness is deemed to be an act of reconciliation when whatever is separating people from each other and or God is removed. This can be done through a gesture, such as offering an apology in which the re-establishment of relationships can begin.[217] Forgiveness can also be shown or experienced through various rituals, some of which are incorporated into the second mode of reconciliation, which is discipline.

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[214] Ibid.
[215] Clebsch and Jaekle, 56.
[216] Ibid., 56-66.
[217] Ibid., 57.

Discipline as a mode of reconciliation is a healing measure with a protective purpose.[218] Rituals are often disciplines used as part of reconciliation. Historically such rituals as confession, communion, and penance have all been symbolic means to reconciliation.[219] For example, confession was seen as a way to absolution and forgiveness, thus building the bridge to reconciliation.[220] Communion, which according to Elaine Ramshaw is "the paradigmatic act of pastoral care," leads to "tablesharing where the community is united" in reconciliation.[221] The ritual of communion is practiced once a month through the spiritual care program at MCC and many boys participate. Some of these boys have stated they find this ritual a manner of connection or even reconciliation, a step towards healing the shame that binds them. Other boys have spoken of a connection to God and often to their community, which includes the other boys, the staff and the chaplain, when they all participate in the sacrament of communion. All of these rituals for reconciliation present powerful tools for pastoral care, including healing, sustaining, and guiding. As I have mentioned previously these four functions of pastoral care are included in the spiritual care program at MCC through groups and in chapel. However, both Lartey and Clinebell have suggested additional functions beyond these four.

Howard Clinebell, while upholding Clebsch and Jaekle's four functions, believed there was a missing function, which was nurturing. He elaborates on this in the context of "growth counseling," a form of counseling he was committed to for many years.[222] Clinebell views the function of the pastoral counselor as a facilitator of growth.[223] He explains that this is done

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[218] Clebsch and Jaekle, 57.
[219] Ibid., 58-59.
[220] Ibid.
[221] Elaine Ramshaw, *Ritual and Pastoral Care* (Philadelphia: Fortress Press, 1987), 13.
[222] Lartey, 66.
[223] Howard Clinebell, *Growth Counseling: Hope-Centered Methods of Actualizing Human Wholeness* (Nashville: Abingdon, 1979), 19.

through a process of nurturing that combines caring with confrontation.[224] Coles agrees with this statement by saying, "some of the best people who worked with the delinquent kids I used to treat were people who knew how to take these kids very seriously but who also knew how to take very little from them in the way of conning," thus balancing nurture with confrontation.[225] Clinebell, according to Lartey, "argues that growth will occur in a relationship to the extent to which caring, that is acceptance, affirmation, grace and love is experienced."[226] Perhaps Howard Clinebell was speaking in attachment theorist terms, and perhaps not, but this function of pastoral care is also included in the MCC spiritual care program within the context of relationship building through attachments.

Lartey agrees with Clinebell that nurturing is another function of pastoral care that must be added to Clebsch and Jaekle's four functions. However, Lartey believes there are at least two more functions needed to complete the circle of pastoral care.[227] These additional functions are those of liberating and empowering, which are especially important in particular cultural contexts.[228] Lartey describes liberating as involving the "intricate and delicate processes of raising awareness about the sources and causes of oppression and domination in society."[229] He goes on to say that "pastoral practitioners are called upon to be involved in social and cultural action for personal and communal liberation."[230] The MCC boys know the occurrences of bondage, of culture, of physical, spiritual, and psychological bondage, all too well; indeed, they reel daily from the resulting trauma. Hence this is not a specific function that has been included in the MCC spiritual care program. The boys at MCC are just children and the intention of the

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[224] Ibid.
[225] Robert Coles, et al., *The Ongoing Journey: Awakening Spiritual Life in At-Risk Youth* (Boys Town: Boys Town Press, 1995), 18.
[226] Lartey, 66.
[227] Ibid., 62
[228] Ibid.
[229] Ibid., 67.
[230] Ibid.

spiritual care program is first to help them stabilize. However, for those few who have the opportunity to stay at MCC long enough to grow chronologically, psychologically, and spiritually stable the idea of liberation will surely be broached.

Empowerment as Lartey defines it has more to do with society in general and less to do with a sense of personal empowerment. For example, Lartey defines empowerment as a "way to enable and motivate persons and groups to think and act in ways that will result in greater freedom and participation in the life of the societies of which they are a part."[231] Furthermore, he goes on to state that, "empowerment is most often a communal affair."[232] While this is essential and vital for much of pastoral care, the main source of empowerment the spiritual care program at MCC will be focused on is personal empowerment for each boy, not communal empowerment. Therefore, this is not a function of pastoral care that is included in the MCC spiritual care program either.

Thus the four original functions of pastoral care, healing, sustaining, guiding, and reconciling as outlined by Clebsch and Jaekle, along with the fifth function of nurturing as proposed by both Clinebell and Lartey, comprise the foundations of the model of the spiritual care program at MCC. However, as previously mentioned, many of the boys come to MCC with a preconceived idea of God, church, and sin that has to be addressed prior to moving into these functions of spiritual care.

Many of the boys have come with ideas of fear, punishment, alienation, sin, and badness in relation to God, church, or spirituality. They have acquired these ideas in a myriad of ways, some through established religion, some through media, some through voices of abusive parents, and some from their peers--but seldom in the context of a loving spiritual care program. Andrew

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[231] Lartey, 68.
[232] Ibid.

Lester believes that children are neglected in times of crisis, often because pastors are simply either too busy or feel inadequate in their knowledge and training to provide care for children.[233] The neglect is widespread, he says "few pastors give any systematic attention to pastoral relationships with children, even those in crisis."[234] Jean Stairs agrees with the idea and elaborates on it when she says, "young children have tremendous and often untapped spiritual capacities that deserve greater pastoral attention."[235] Hence, these boys who truly need to experience healing relationships and words of hope rarely get them, often because pastoral care is not designed with them in mind.

There are many ways to design and define pastoral or spiritual care as explained in the Definition of Terms section, but most do not seem to apply easily to traumatized children. Hence, as Jean Stairs suggested, there is a need for a spiritual care programs specifically designed to meet the needs of all children, including traumatized children.[236]

This project specifically sought to answer that need by designing the MCC spiritual care program, including Clebsch and Jaekle's four foundations and Clinebell's fifth, that of nurturing, in a way that would address the needs of traumatized children. However, the program could not have been designed or developed without fully applying the knowledge we gained by investigating how trauma and attachment interruptions impede spiritual awareness and connection. Therefore, as we move toward the design chapter, a reminder of some of the things we learned earlier seems appropriate.

For example, traumatized children often act out in negative self-destructive ways, frequently as a defense or coping mechanism or a learned behavior. Furthermore, we learned

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[233] Andrew D. Lester, *Pastoral Care With Children in Crisis* (Philadelphia: The Westminster Press, 1985), 15-20.
[234] Ibid., 27.
[235] Stairs, 156.
[236] Ibid., 156.

that a child without a secure attachment might exhibit some of the same negative acting-out behaviors due to a developmental impasse or an inability to trust, and thus have no basis to feel safe. How then can the children displaying these behaviors be approached and introduced to a spiritual care program that will hopefully facilitate an attachment, which may bring, healing, sustaining, guiding and finally reconciliation?

Furthermore, how can this program be created on the campus of a residential facility in which there is an inherent absence of attachment figures?[237] Yet, as Bowlby consistently proclaims, "intimate attachments to other human beings are the hub around which a person's life revolves … from these intimate attachments a person draws his strength and enjoyment of life."[238] Thus, a substitute attachment figure must be found for these children if there is a hope of healing for them. Bowlby continues with the proclamation that it is possible for a consistent, comforting, known, and trusted person to fill the void and become the needed attachment figure.[239] Yet how is this consistent attachment possible within the confines of residential care?

Bowlby suggests using Winnicott's technique of allowing "free expression of what are traditionally termed dependency feelings" between the potential attachment figure and the child with the result being the development of an attachment relationship and the recovery of the lost sense of self for the child.[240] Kagan suggests that "attachment-related behavior problems require attachment-centered interventions" such as "listening to children and learning how to respond to their needs for nurture, consistency, predictability, safety and discipline within an enduring and bonded relationship."[241] Henri Nouwen said the key to a healing relationship is not the quantity of the relationship but the quality, and that the quality must include, "a deep human encounter …

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[237] Howe, 143.
[238] John Bowlby, *Loss: Sadness and Depression* (New York: Basic Books, 1980), 442.
[239] Ibid., 276.
[240] John Bowlby, *Secure Base: Clinical Applications of Attachment Theory* (London: Routledge, 1997), 54.
[241] Kagan, 26.

with compassion at the core" through which the discovery of self and its relationship to God will come.[242]

Hence, God is brought into the mix. Perhaps the most consistent and tangible attachment relationship these boys can hope for is their relationship with God. Nevertheless, how do the boys arrive at any type of attachment relationship with a God they may seldom be able to conceptualize or understand, and when they have no means or venue in which to do so?

Certainly, a spiritual care program offered on the campus of MCC is a starting place to introduce and foster this attachment relationship with God. However, more than just a program is needed, because, as we know, the degree of environmental support a child feels can make the difference in how much residual damage he or she will or will not continue to have from his previous trauma history.[243] Jean Stairs offers three enticements with which to enrich the environment so children can know that their souls are safe and connected.[244] She offers these enticements with the assumption that "children possess an innate spiritual hunger and openness and that this is felt and deeply evident in children who are first and foremost in need of love."[245] She goes on to say that "for the child, love is almost more necessary than food" and it is through "contact with God that the child experiences unfailing love."[246] The enticements Jean Stairs suggests are the use of ritual, the enticement of wonder, and the encouragement of prayer, all of which have been incorporated into the spiritual care program of MCC.[247] She views these enticements as creating an environment in which the children can "meet, experience, contemplate and respond to God," thus perhaps finding their consistent attachment

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[242] Henri J. M. Nouwen, *The Wounded Healer* (~~New York: Image Books, Doubleday~~ Garden City, NY: Image Books, 1979), 39.
[243] ~~Jane~~ Middleton-Moz, ~~*Children of Trauma: Rediscovering the Discarded Self* (Deerfield Beach: Health Communications, Inc., 1989)~~, 14.
[244] Stairs, 155.
[245] Ibid., 168.
[246] Ibid., 169.
[247] Stairs, 171-184.

relationship.[248] This will provide the child with an increasing sense of self, and the ability to finally trust, hopefully decreasing the child's need to act out with negative self-destructive behaviors.

The spiritual care program at MCC was crafted with the needs of traumatized, attachment-deficient children in mind while adding the Clebsch and Jaekle components of pastoral care along with nurture and including Stairs' enticements. Establishing a new attachment relationship with God via the spiritual care program, in which the children can experience healing, is hope-inspiring but may be wishful thinking, although with a well designed program perhaps some of the wishfulness can be eliminated and replaced with a concrete model, as the next chapter illuminates.

[248] Ibid., 171.

Chapter 4

Design and Description of MCC's Spiritual Care Program

The trials and tribulations of implementing a spiritual care program at MCC were numerous. Initial hurdles to overcome included finding sufficient time, money, and space, as well as contending with naysayers. The next major hurdle was getting the staff, the administration, and the board of directors to buy into the idea. Not allowing the children to participate during the building stage was also emotionally difficult, but fortunately, Friesen's model gave us a basic structure to follow that sped the process along. Alas, there were some minor detours on the way, mostly centered on making adaptations to the Friesen model to better fit the MCC situation.

The first place I began adapting was by setting specific goals for the MCC spiritual care program. The goals for the MCC program were carefully crafted, as were those of the Friesen model. However, the Friesen goals were much more global in nature while the MCC goals were quite specific.

For example, the first goal of the MCC spiritual care program is to support the MCC mission statement, which is "to help troubled children gain the skills, knowledge and self-esteem essential to personal maturity and successful family functioning."[249] Each of the following goals contribute to accomplishing the first goal. All the goals combine and work together to create an environment in which the abused and traumatized children of MCC can find safety, connections, and possible attachment opportunities through spiritual care, which may ultimately increase their healing and growth.

The second goal is to match the program to the spiritual needs of each child. This I expected to accomplish in much the same way the Friesen model did. This was done through

[249] Beltran, 2008.

various assessments of the child, including age, developmental stage, level of trauma, and attachment history. Additionally, we reviewed the religious or spiritual history of each child in an effort to address and maintain some type of belief system consistency. Once the assessment was completed and reviewed by the treatment team (consisting of the chaplain, the cottage manager, the therapist, the mental health rehabilitation specialist, the psychiatrist, the clinical manager, and the clinical director), an age and developmentally appropriate treatment plan centered on attachment, and informed by the child's chosen level of spirituality, was implemented. Each person of the team has a specific area in which to focus his or her healing talents, including the chaplain, who works in concert with the entire treatment team, maintaining holistic healing with attachment building as the goal.

The MCC spiritual care program's third goal is the same as one of Friesen's goals. This goal is to increase collaboration and interaction in the local community. The Friesen model is extremely successful in increasing collaboration and interaction between St. Joseph's and the local community. One example of this collaboration is when a Native American elder from the community came to lead the traditional Native American Talking Circle held at St. Joseph's in honor of the Native American children who resided there.[250] Unfortunately, MCC is currently not meeting this goal successfully. While various local service clubs do occasionally come to campus to paint a building or help till a garden, the ongoing interaction between the local community and MCC is very limited and not focused on spiritual care.

Finally, the program cannot work without defining the population it serves, which is the fourth goal. As the Friesen model points out, the children are part of a much larger system, including their families of origin, their past and present caretakers, their lawyers and county workers, their cottage mates, their school peers, the members of staff assigned specifically to

[250] Friesen, 74-73.

them, as well as the overall staff of the agency. Given the extent of this population, defining whom the program serves becomes quite challenging. Because of its greater funding levels and staffing, the Friesen model did not struggle with this issue and was therefore better able than MCC to invite the participation of each boy's supporters outside the residential facility. While MCC would like to serve spiritually every person whose life intersects with the MCC boy's life, it simply is not possible for one chaplain to do that for 65 boys. Therefore, the breadth of the population served in the MCC spiritual care program is limited to the residents and staff of MCC, with the greatest emphasis being on the boys. Certainly, the boy's families and caretakers are invited to participate in the Sunday evening chapel program, as is the community at large. Unfortunately, few accept this invitation.

Thus, while the Friesen model and the MCC spiritual care program shared many goals and the Friesen model was a great fit for St. Joseph's, in many ways it was not a great fit for MCC. These reasons included different staffing patterns, changes in the worship services both on and off campus, the collaboration between local communities and the programs, plus the breadth of the populations to be served by the different programs.

Therefore, programmatic adaptations had to occur and the first place I started was with staffing. Friesen's staffing model was premised on serving about 150 children, whereas MCC would be serving an average of 65 boys and would therefore need fewer staff. Friesen's model employed two part-time chaplains and a fulltime director of the spiritual care program. The smaller population, along with financial constraints, meant MCC we would employ only one fulltime chaplain, who would also serve as the director of the program.

Therefore, the job of the chaplain for the MCC spiritual care program, which highlights the ministry of presence, and is defined as the act of consistently being there to provide support

when support is needed, would be nearly an impossible task for just one person. However, the ministry of presence is a key component of the MCC chaplain's work, as well as in Friesen's model, so we had to find a way to get more help.

Friesen's model uses volunteers in several areas, such as to conduct tours on St. Joseph's campus for the "Project Aware" program. In addition, volunteers from local churches come to St. Joseph's to participate in the Sunday evening chapel services. This contact helped build relationships, possibly creating attachment opportunities for the children at St. Josephs. Often the volunteers invited the children to their home churches. The volunteers transported the children to and from activities and worship services at their churches. Because these relationships frequently bloomed into mentor relationships, the volunteers developed a formal mentor program. At MCC, neither a volunteer nor a mentor program has yet been established but my hope is that both will occur as a natural outgrowth of the spiritual care program.

In the Friesen model, the various spiritual care staff staggered their work hours so that during most of the children's waking hours at least one of them would be on campus, which increases the window for attachment opportunities. Because MCC only has one person on its spiritual care staff, this type of coverage is simply not possible. However, the chaplain is on campus Sunday through Thursday for a total of 40 hours, typically arriving at 11 a.m. and leaving at 7 p.m. Monday through Thursday. From eleven until shortly after two when the boys return home to MCC from school, the chaplain has time to visit and interact with the staff and local community members as well as prepare for the day with the boys.

The tempo of the chaplain's day changes dramatically around 2 p.m., moving from preparation to action. During the next five hours, the chaplain is typically busy interacting with the boys, consistently striving for attachment opportunities. The chaplain makes rounds

immediately after school is released, beginning when she walks across a patch of grass to the schoolyard where she meets the boys and accompanies them to their cottages, interacting with them on the way. Every day she makes a consistent effort to be there in the schoolyard waiting for the boys. Her consistency acts as a building block for potential attachment relationships and is highly important for the boys.

Once at the cottages, she visits each boy, briefly, as a reminder that she is around and available to the boys. Attachment is not possible without such consistency and availability. On school days, the boys have mental health group activities for the first couple of hours after returning home. However, each day at least one and usually several of the boys need a little extra care, which is exactly where the chaplain fits in.

The chaplain notices and practices the ministry of presence. Therefore, if a boy or boys are having difficulty with the transition from school back to the cottage or into a mental health group, the chaplain will typically intervene by taking them for a walk, sometimes back to the chapel but more often on a nature walk somewhere on the 30-acre MCC campus. It is, as she calls it, a spiritual adventure walk and a bonding time. These are often quite healing journeys as they are usually filled with attachment opportunities. The walks are wonderful for the boys, giving them opportunities to be heard one-on-one, thanks to the chaplain's careful listening. The walks are also helpful to the staff because the boys are typically much calmer and more peaceful when they return from them.

By five p.m., the boys are usually preparing for and eating dinner in their cottages. During this time, the chaplain prepares for the evening spiritual care group, which will begin by six-thirty pm. Each night, Monday through Thursday, a different group meets, each with a different focus. Monday night group is the sacred writings group. The chaplain or a boy will

read a passage to the group from a sacred text such as the Bible, the Koran, or Kahlil Gibran's *The Prophet.* Once the passage is read, the entire group discuses how it applies to their lives today and how it applied to life when it was written. The discussions can be quite lively with boys and staff of such a wide range of ages and developmental levels participating. Meeting the boys where they are at is central to securing trust, a building block for relationships and attachments.

On Tuesday nights, the spiritual care program comes alive with board games and sometimes video games. The spiritual lessons that can be learned from a simple game of Candy Land range from compassion to honesty. The boys learn how cheating hurts them all by violating the community trust which is required for everyone to enjoy the game. The game Mousetrap can teach the boys how teamwork can create amazing things but greed will destroy it all in a minute. Game night has been a tremendous success; often the boys continue to speak throughout the week of the lessons they have learned from the games. This group builds a growing sense of community for the boys involved in it, typically increasing their sense of belonging and thus attachment.

Wednesday night is a quiet meditation spiritual care group. Some of the boys proclaim this their very favorite group while others struggle to find any value in it at all. The session typically begins with ten to thirty minutes of guided imagery focusing on a walk through the woods to a warm and uninhabited beach. During the "walk" the leader suggests to the boys the spiritual things they might find along the way, including fellow travelers. For some boys this has been a wonderful experience, but for most trauma survivors, we have learned that thirty minutes is simply too long to sit still, let alone focus on a particular task. Therefore, the chaplain often shortens the meditation time to three ten-minute increments with five-minute breaks in between.

This works much better for many of the boys, but for some, due in part to their trauma histories, ten minutes was still too long. The boys, who have knowledge of the fact that the chaplain specifically designed the curriculum with them in mind, feel special, and this has the potential to build bridges of connection that become the beginning of attachment.

Thursday night is currently media night. The spiritual care group enjoys movie clips, CD tracks, or book chapters. For example, if a movie clip is shown, typically a discussion of the spiritual implications of the clip follows. Most recently, the group has discussed at some length Sam, Frodo's guide, friend, and perhaps angel-like figure from the movie *Lord of the Rings.* The group pondered why Sam was willing to risk his own life for Frodo even though Frodo was being very unkind to Sam. Most of the boys have never experienced that sort of connection or attachment. The boys ask for specific movies, songs, and books to be used during this group, and sometimes they bring in their own CDs or books for review and discussion. This can create an attachment to the activity by providing the boys with a sense of ownership.

Friday and Saturday are the chaplain's days off. Many of the boys go off campus for the weekend and the boys who stay on campus are usually involved in the on-campus weekend activities programs.

Sunday is the fullest day of the week for the spiritual care program. The chaplain puts out a schedule each month regarding which church she will be taking boys to visit on each particular Sunday morning. The boys sign up by Thursday afternoon to attend the following Sunday morning's off-campus worship service. Adhering to this timeframe is important for both the boys and the chaplain. For the chaplain, it is crucial in order to arrange transportation and staff coverage for the boys. For the boys, it is important because most of them are trauma survivors and as such need a high level of consistency and continuity to feel safe. Furthermore,

without that potential establishment of safety, creating an attachment possibility would be extremely difficult.

Nevertheless, once these things have been arranged, the chaplain phones the worship leader of that particular worship center to let them know the MCC boys will be attending on Sunday. When Sunday morning comes, the chaplain rallies the boys into waiting transportation and they go to the local worship center. Often the return trip includes fun and food at a local fast food restaurant, partly because the boys so rarely get the opportunity to partake of such things. Another reason for the fun and food stops is the potential for further creating a sense of community through offering this shared activity.

While not as often as would be desired, occasionally on Sunday afternoons the boys, some staff, and the chaplain engage in shared activities on campus, such as softball games, BBQs, or structured nature hikes. However, often this is a time when the chaplain gets to make rounds and checks in, one by one, on each boy. By doing so, she is able to provide individual spiritual care, and another attachment opportunity, for a single boy, who may not be willing to attend a group or worship service. By five p.m., the chaplain is busy preparing for Sunday night chapel services.

Sunday night chapel service is a somewhat traditional chapel service, though shortened for the sake of the boys who have trouble sitting still for longer periods. The service lasts between twenty and thirty minutes and on the second Sunday of every month includes Eucharist. This is a sacrament and ritual that, as previously mentioned while describing the four functions of pastoral care, has much power in creating connection. The Sunday night chapel service is distinctly Christian and consists of scripture reading, prayer, and a short sermon.

Each night and every Sunday, the groups and worship services are tailored specifically for the boys who live on campus at MCC. The Friesen model does the same thing by fashioning the weekly spiritual care groups and Sunday worship activities to the specific spiritual, cultural, and religious needs of that Home's population. For example, their population includes a large number of Native Americans, so one of the weeknight groups focused on Native American spirituality.

By maintaining a focus on the cultural needs of the children on the St. Josephs campus, the Friesen model has also widened its financial opportunities. The Native American tribes near St. Joseph's support the home's spiritual and cultural programs with both volunteers and money. So far, MCC has not found this kind of support from an ethnic or cultural group. Occasionally a private individual will donate materials or money, but this is not the norm. However, currently a private individual donates money for half of the chaplain's salary. Without this donation, the MCC spiritual care program would not be possible, which is quite different from St. Joseph's.

Nevertheless, given the campus-wide collaborative nature of treating the children that the Friesen model suggests, I hope that the MCC spiritual care program, while limited compared to the Friesen model, will nonetheless make a difference to the children who reside there. The following chapter builds on that premise.

Chapter 5

Methodology and Results

In this chapter, I review the methods I employed for collecting data, including the selection of participants and the variables measured. Furthermore, I describe and assess the outcomes and suggest some correlations and conclusions, remembering that my thesis is:

> *By participating in a spiritual care program on the MCC campus, children fulfill some of their previously unmet psychospiritual needs. One way of measuring this is in a decrease in their negative and often self-destructive behaviors.*

Throughout this project, I have proposed that nurturing a child's spiritual life enhances their ability to form and maintain attachments, a capacity which trauma and abuse have often stymied. Lack of attachment increases a child's need for defenses, which are frequently expressed through negative and self-destructive behaviors. Hence, if it is possible to heal trauma-inflicted attachment difficulties through spiritual care, then the resulting attachment may evidence itself in a decrease in self-destructive behaviors and a reduction in the number and severity of the documented serious incident reports (SIRs). However, to test this hypothesis, a beginning place had to be established.

I began by acquiring a pre-spiritual care program baseline number of SIRs for the entire MCC campus. I gathered this data from the Quality Systems Department (QSD) at MCC. They gather all the SIR data daily, and then compile it on a monthly basis. Hence, while I monitored attendance of the boys at the spiritual care programs, the QSD monitored the monthly SIR occurrences and their severity. Differentiating the severity of the SIRs became an onerous task, because, what one staff person perceived as a severe violation, another might perceive as being moderate.

The SIRs are broken down into various categories; however, one category is easier to measure than the others. These SIRs are the ones that identified escalated behaviors that resulted in a child being restrained. A restraint is a physical movement that a staff person engages in with a child in an attempt to prevent the child from hurting himself or another person. There are very strict guidelines outlining what type of restraint can be used for which behavior, as well as the allowable length of the restraint. There is in-depth training each staff member must successfully complete before they can engage in any type of restraint with a child. Restraints are always used as a last resort; only when a behavior has escalated considerably is restraint justified. Each time a restraint is engaged in with a boy an internal investigation by the QSD is launched. This investigation reviews the total time of the restraint, the staff member performed the restraint, as well as the type of restraint used, and finally what action prompted the restraint.

The other group of SIRs are difficult to lump into one category as they include such things as hospital visits, including emergency visits, illness, injuries or psychiatric hospitalizations. SIRs in which police are involved form part of this category. However, police involvement does not constitute one simple thing. It can include asking the police to file a report for a broken window, or a fight in which someone wants to press charges, or to file a missing person's report, which by law has to be done anytime one of the boys leaves campus without permission (known in QSD parlance as going AWOL). Thus, police involvement can mean a variety of things. Substance abuse or suspected substance abuse can also generate an SIR which can include police involvement, or a hospital visit, or all three. Finally, anytime any type of allegation is made, including an allegation of child abuse, sexualized behavior, physical abuse, or neglect, an SIR is written, reported, and investigated immediately.

Therefore, in many ways, the last of the two categories of SIR are far more severe than the first category, involving the behavior-induced restraints. In the second category, which I have labeled "other SIRs," there are more physical injuries, and more behaviors that include police involvement or hospitalizations, including AWOLs, substance abuse, other types of abuse, and extreme psychiatric events. The first category, which I have labeled as "behavioral SIRs" involves escalated behaviors that result in restraints. These behaviors are most often fights between boys or angry outbursts involving throwing or breaking things; they never intentionally involve injury to self or others, which would be classified as a category two SIR. Unfortunately, these escalated behaviors are very typical for children of trauma with unmet attachment needs who are living in a level 12 residential facility.

I am inclined to celebrate when a boy moves from having an SIR in the category two or "other" group to an SIR in category one, or the "behavioral" group, as I see this as a reduction in the severity of his acting-out behaviors and perhaps an increase in his feelings of stability and attachment. However, my bias may be showing. I have been a licensed clinician in this field working with these children for several years and I may, perhaps inaccurately, see improvement where others do not. Furthermore, I am quite conscious that my pastoral eyes, soul, and heart may be looking for any signs of healing in a place where there are consistently so very few.

Regardless, there are concrete things we can measure, including the boys' attendance in the spiritual care programs. We took attendance at each spiritual care event during the month. Five events were offered each week over the course of the measurement period, which included thirteen weeks (65 events) over the course of three months (September, October, and November).

The very first measurement was a pan-campus baseline total of all SIRs that occurred in August of 2008. This measurement was considered the baseline measurement because the

spiritual care program had not been implemented prior to September 1, 2008. My premise was that by reviewing the SIRs prior to the implementation of the spiritual care program I would get a baseline reading of behaviors. This baseline I would then compare with the new SIRs, month by month for the next three months, in search of any changes.

I began collecting spiritual care data for this project on September 1, 2008. I did this by asking the chaplain to have the boys who attended the spiritual care program activities to sign an attendance sheet. The Quality Systems Department continued to collect and process SIRs during this time. I intentionally stayed uninformed of the SIRs specific to each boy unless it was an emergency. I did not want to have any opportunity to create any type of extraneous variables by letting the amount or severity of SIRs of an individual boy affect my interaction with that boy. Unfortunately, my position as executive director of treatment at MCC prevented this from always happening, for if there was a boy who was truly struggling with the category two SIR, including hospitalizations or AWOLs, I had to become involved. Therefore, I removed myself from my participation in the spiritual care program for the duration of the data collection to minimize my possible impact on the boys or the data.

The following table exhibits the number and severity of SIRs, by month, over the course of this project. The table includes the baseline month of August, however, there are not any spiritual care program attendee's numbers for that month because as previously noted the program did not start until September.

	August	September	October	November
Other SIRs	40	29	29	26
Behavioral SIRs	9	20	22	23
Total SIRs	49	49	51	49
Total MCC Population	56	59	61	62
Spiritual Care Program Attendees	n/a	54	59	60

As can be seen from the table, the total baseline numbers of SIRs for August were 49; the number of "other" SIRs totaled 40 and the number of "behavioral" SIRs totaled 9. There was an average of 56 boys, out of a possible 66, living on campus for the month of August. This was due in part to the school being on summer break, and many of the boys were temporarily gone during this time.

Although the August baseline total SIR count of 49 was the same as that of November, the severity appeared to have decreased, with August's other SIRs at 40 and November's other SIRs at 26. However, the behavioral SIRs for November at 23 far exceeded the behavioral SIRs for August by 9. There was a large population difference on campus during the course of the study, with August only having 56 boys on campus and November having 62 boys on campus. The additional 6 boys may have affected the behavioral SIR count; my hunch is the greater the competition for the limited resources becomes, the greater the increase in negative, acting-out behaviors.

Attendance for the spiritual care program grew each month. The number of boys attending the spiritual care program in September was 54 and by November it was 60 boys. There could be many reasons for this, including an increase in the total population on the MCC

campus during that time. Furthermore, in September, the spiritual care program had just begun and some of the boys may have been waiting a bit to see what others thought, or they may have waited to see if they trusted the chaplain, or to see if the groups seemed safe. Whatever the reason, by November 60 or all but 2 of the boys on campus were attending at least some of the spiritual care program activities.

Attendance varied greatly over the three-month period with November being the month with the greatest number of boys (60) attending and the greatest number of activities attended (378) with an average of 6.3 activities per boy. During the month of October, the attendance at spiritual care activities was the lowest (242) with the average attendance per boy being 4.1 activities. However, *more* boys attended (59) the spiritual care program activities than they had in September. September, the first month of the data collection, had the fewest number of boys (54) attending the spiritual care program but when they attended they attended often (258), with an average attendance of 4.8 activities per boy.

Given the unexpected lower attendance and higher overall total SIR data for October, further investigation was needed. The month of October on the MCC campus overall was very unstable. There had been contract confusion with the main funding and placement source for some months, which culminated in October with several boys coming and going, so there was a large shift in campus stability. When new boys come, the system itself is temporarily destabilized, as homeostasis is disrupted. However, the stability usually returns quickly if the foundation of boys who have been on campus the longest remains the same. Unfortunately, in October, several of the boys who had resided on campus the longest left and several new boys came at the same time. This created a great deal of tension and instability on campus.

Furthermore, during October, the main meeting place for the spiritual care program had to be relocated due to construction. This project had been scheduled around the construction schedule but there were construction delays, which displaced the spiritual care program beginning in October. As is reflected in the attendance documents during the middle of October there were a couple of days when the spiritual care program events were completed interrupted and did not occur. A combination of all these variables likely influenced both the number of boys attending the spiritual care program and the volatility of the campus. These may have been confounding influences, which created the increased number of SIRs. The fact that by November all of these complications had been resolved and the level of overall SIRs had decreased, while attendance at the spiritual care program had increased, provides support for this notion.

Appendices 2, 3, 4 and 4a are lists detailing the attendance and spiritual care participation of each boy for each month, as well as the occurrences of both "behavioral" SIRs and the "other" SIRs. By reviewing these appendices, three distinct categories are visible, category one contains all the boys who attended more than 8 spiritual care program events per month, category two includes all the boys who attended 4 to 8 spiritual care events per month and the third category includes the boys who attended 1 but less than 4 spiritual care program events per month.

For example, in September and November, the attachments sorted by attendance show that the higher a boy's attendance at the spiritual care program the lower the number of SIRs overall. More specifically, in September, the highest number of events attended by any one boy was 13 and this boy did not have any SIRs for the entire month. This was true for all 6 boys, who fell into the first category and attended the spiritual care program more than 8 times that month; none of them had any SIRs for the entire month.

The second category of boys, a total of 24, who attended spiritual care program events 4 to 8 times, in September, had 24 overall SIRs. However, these SIRs were unequally distributed with two of the boys who attended only 4 times in the month having the highest amount of individual SIRs for the month, which totaled 4. These 4 SIRs were also unequally distributed, with one boy having 3 behavioral SIRs and only 1 other SIR while the other boy had just the opposite, 1 behavioral SIR and 3 other SIRs. There were also 10 boys with attendance between 8 and 4 who did not acquire any SIRs for the entire month. Thus within the second category of attendance, 4 to 8 times a month, there occurred both the highest numbers of SIRs acquired and the highest number of boys with zero SIRs.

Yet for the 24 boys who fell into the third category, only 14 overall SIRs were reported with no single boy acquiring more than 2 and 13 boys acquiring none. Finally, out of all 49 of the SIRs, only 20 were behavioral, and the majority of those, 15, were acquired by the boys in the second category, those who attended between 4 and 8 times a month. However, when it came to the other SIRs, the third category, less than 4 times a month of attendance surpassed the second category, 4 to 8 times a month, with the third category acquiring 10 other SIRs and the second category acquiring only 9. As I mentioned earlier, often the other SIRs are more severe (including psychiatric hospitalizations and or police involvement) than the restraint, behavioral SIRs. That being the case, the boys who attended the spiritual care program the least amount of times in September had the greatest amount of severe trouble during that month.

October presented a different picture in all areas. First, the highest attendance number for the spiritual care program events for the entire month was only 9 times and only one boy out of a possible 59 boys was in this first category of more than 8 attendances in the month. In this case,

it did remain constant with the results of September in that this boy with the highest attendance rating also did not have any SIRs at all.

However, in the second category for October, with attendance of 4 to 8 times within the month, there were 39 boys with a collective total of 27 SIRs. One boy in this category had the highest individual number of SIRs (6) for the month while 22 boys in this category had zero SIRs. Once again, the other SIRs were more plentiful with 15 occurrences than the behavioral SIRs with 12 occurrences within this category.

Nevertheless, in the third category of boys for October, those attending fewer than 4 times a month, the total SIRs were 14, with the other SIRs at 6 and the behavioral SIRs at 8, a reversal from category two. Out of the 19 boys in the third category, only 7 had SIRs; thus 12 boys had zero SIRs.

Therefore, for October, unlike in September, the boys in category two (4 to 8 attendances) had more severe SIRs than any other category in the month. Furthermore, the boys in category two also had the worst behavioral SIRs averaging 3.2 behavioral SIRs per boys vs. an average of 2.37 for the boys in category three. Thus, the boys in category two had both the most severe SIRs and the most behavioral SIRs for the month of October, even though they attended the spiritual care program more often than their category three counterparts did.

In November, the attendance in the spiritual care program rose dramatically. Instead of just one boy being in category one and attending 9 times like in October, there were 11 boys in category one in November with the highest attendance number at 18. In addition, of those 11 boys in category one only 4 had SIRs, leaving 7 without any SIRs at all. There were 11 overall SIRs for the boys in category one, with only 3 that were other SIRs, leaving 8 behavioral SIRs. Interestingly, the boy with the highest overall SIRs was in this category with 10 attendances and

6 total SIRs, 4 of those being behavioral SIRs leaving 2 other SIRs. This was the highest number of SIRs recorded throughout the entire project in category one.

While category two had a much larger number of boys in it (30), they had only 27 overall SIRs. This was lower than category one given that the average SIRs in category one was 1 and the average for SIRs in category two was 0.9. Furthermore, in category two, there were 12 behavioral SIRs and 15 other SIRs, exactly the same as October category two group. In addition, in category two there were 22 boys without any SIRs, leaving just 8 to amass the 27 SIRs.

Finally, in category three, for November, there were only 11 boys, 9 of whom had zero SIRs. This left only 2 boys who acquired 3 SIRs, 2 of which were other SIRs, leaving 1 that was a behavioral SIR.

Although November had the highest number of boys, 60, attending the spiritual care program it also had the lowest number of other SIRs since the project began, with only a total of 26 out of 49 overall SIRs. This is much lower than the baseline number of 40 other SIRs that occurred in August prior to the start of the spiritual care program. Although the overall number of SIRs remained consistently at 49 in August, September, and November and only rose to 51 in October, the severity of the SIRs decreased a great deal from 40 other occurrences of SIRs in August to 29 in September and October and only 26 in November. Therefore, it is possible that the addition of the spiritual care program to the MCC campus did make a difference by reducing the severity of the boys' acting-out behaviors.

Unfortunately, the occurrences of behavioral SIRs increased from 9 in August to 23 in November, which reflects that the milder, negative, acting-out behavioral issues of the boys were not reduced. Perhaps this was a result of the boys managing their feelings in less destructive ways, which would be a positive outcome. Sadly, there were just too many extraneous variables

present to make any sort of assumptions. This is exactly why modifications need to be made as suggested in the next chapter.

Chapter 6

Summary and Future Research

Through this research project, many things were learned, both anticipated and not. However, the conclusions of all that we learned were ambiguous. While a spiritual care program imbedded in a children's residential care facility's curriculum has the theoretical potential to reduce the occurrences and possibly severity of these children's negative, self-destructive behaviors, more research into the outcomes needs to be done before any conclusions can be reached.

Some of the resulting data from this project look promising. For example, the dramatic decrease in the number of "other" or more severe SIRs, over the course of the project, may be evidence that the severity of the negative self-destructive acting-out behaviors of the boys at MCC did decrease, because some type of attachment, or other healing, occured through the spiritual care program. However, the decrease in "other" SIRs was surpassed by the dramatic increase in the number of "behavioral" or less severe SIRs across the projects' time span, possibly signaling that no healing of attachment wounds occurred. Certainly, it could be postulated that the "behavioral" SIRs increased because the boys felt more stable and did not have a need to engage in the more severe "other" SIRs. Yet, due to their trauma and attachment wounds, they still needed to engage in some type of negative acting-out behavior, and they chose to act out in the less severe ways. However, the data was just too ambiguous to identify any concrete correlations or conclusions.

Perhaps one of the things we can take away from this project, is validationthat many traumatized boys who live in residential care settings, carry with them an attachment wound that

injures their souls. The increasing attendance at the spiritual care program may support this claim.

Furthermore, my experience of the boys continues to tell me that these boys often "scream" out in pain asking for healing, yet we are seldom attuned to what their "screams" mean and find them irritating at best. Oftentimes their "screams" are not audible as such, instead, they are acted out in behaviors. They run away but usually they are not so much seeking a new place to live as secretly hoping that someone will come looking for them. In short, they run away seeking to be found. They may throw a rock or a punch hoping that someone will take their arm, look at them, notice them, if only for the instant it takes to ask them to stop. We learned that the longer their screams go unheard, the more they crank up the volume of their actions, sometimes to the extent of seriously hurting themselves or others. Then they scream to the police officers or the doctors who have hospitalized them but, alas, even they do not always hear them, and so their pain grows deeper.

The literature spoke to delinquency and lack of attachment and I believe this project highlighted that possible connection. The vast majority of the boys living at MCC come without any real attachment relationships, exhibiting negative, often self destructive behaviors. We did see some evidence that perhaps the beginning of healing for these boys requires very little, sometimes as little as a look, a nod, or a smile.

The advent of the spiritual care program at MCC in turn brought looks, nods, and smiles from the boys themselves. It created a new "place" for the boys to be, a place where they could be seen. Over time, more and more boys flocked to this place. That little attention they got from the chaplain, and the hope for a potential attachment was enough for some boys. Their behaviors changed, and they no longer needed to "scream" silently through destructive actions. They now

trusted they could be heard, just by being. This was especially true for one boy whom we will call Tom.

Tom came to MCC devastated because his mother had just recently died, and due to his resulting negative, acting-out behaviors, his grandmother and other family members had come to the hard choice of asking DCFS to provide for him. Tom arrived extremely withdrawn, and overwhelmed with grief. The only responses Tom gave were angry. He appeared to be a very angry, violent, and defiant boy when he was not shrouded in sadness and isolation. We were at a loss for how to help this child, until he told his therapist that his mother had given him her Bible before she died, and he wanted it back. Tom's most recent caretaker had not sent the Bible with him when he came to MCC.

It happens quite often, when the children in residential care are moved from one place to another, that their belongings do not move with them. They often come to the new placement with nothing. With this unfortunate reality staring us in the face, we began the quest to retrieve this Bible. The therapist told Tom the same thing every day when he asked about the Bible. She said we were doing all we could to find it, and she told him to keep the faith. This was our clue that spiritual care may mean a lot to this boy. The chaplain was called in. In Tom's treatment plan, we added individual sessions with the chaplain at least once a week. The chaplain also decided to ask Tom to help with the spiritual care program activities. She asked him to do readings during chapel services, and to help facilitate some of the nightly groups during the week.

Tom had become a bully. He intimidated the younger, smaller kids, even though Tom was just 11 years old himself. However, once he began helping the chaplain to facilitate the groups, often by helping the younger boys with various activities, his bullying of them stopped.

Tom had begun fights and egged kids on who were on the verge of fighting, just to watch the ensuing fight. However, that stopped too, as he often helped the chaplain settle boys down during chapel services. Tom could be heard telling the boys on the way into the chapel that there was no fighting allowed, and they all needed to give the chaplain respect while they were there. Tom began and continued to be one of our biggest behavioral and treatment issues for many weeks, until he connected with the chaplain. At least in chapel and during the spiritual care activities, his behavior had improved, he had changed dramatically. Tom continues to have a strong relationship with the chaplain; they occasionally go off campus for lunch together. The chaplain says she counts on Tom to help her with activities, and with the other boys. She says he is reliable, kind, and even loving.

Interestingly enough, those would not be the words of the staff in his cottage. Back in his cottage, Tom continues to struggle. He is still occasionally a bully and has had a few fights. However, his level of negative, self-destructive behaviors have declined. When I asked him why things were so different in the cottage compared to the spiritual care program activities, he told me that he respected and liked Gail, our chaplain, and that he felt closer to his Mom when he was part of spiritual care. He also said the pain was not so great for him when he was with Gail or in the spiritual care activities, so he didn't have to try to get away from it so much. The only way he ever got away from it before was by being angry, and he said he was so glad he did not always have to do that anymore.

A few months ago, we finally located his Bible and managed to get it for him. It is his most prized possession and he has asked his cottage manager to keep it safely tucked away in her office. However, Tom spends a great deal of time daily with this Bible, often reading it, sometimes just holding it, and he has shared this Bible often with Gail. With the help of his

therapist, and with guidance from the chaplain, he made and decorated a very special box to hold this, his mother's Bible. Perhaps his mother's Bible is the attachment figure in this case or perhaps it is Gail, the chaplain, or perhaps it is his therapist, or his cottage manager, or maybe it is the love of God expressed through all of these things, including the spiritual care program, that has helped facilitate this change and mediate the trauma wounds in Tom. We cannot know for sure. All we do know is that his participation in the spiritual care program brings out the very best in this boy and he seems happiest there. This is was not always the case for all the boys.

As one might expect, for some of the boys this inclusion in the spiritual care program or small amount of attention they got from the chaplain was not enough. More often than not, however, it did make things better and seemed to give most of the boys hope. While many of their behaviors were still troublesome, they were less likely to be involved with the police or be taken to the hospital for an emergency hold. Most of them moved from the most severe behaviors to lesser infringements. I saw this as a signal that they had some hope, maybe because they were being acknowledged, and maybe because they were beginning to trust that their soul pain would lessen, maybe because attachments were forming.

Unfortunately, there were also the boys who did not move from more severe behaviors to lesser infringements and who still seemed to feel disenfranchised. One boy, whom we will call Dick, was 17 and resided in our substance abuse treatment cottage. He struggled mightily, even though he attended the spiritual care program activities often and almost always attended and actively participated in chapel. Dick also spent a great deal of time with our chaplain. The chaplain regularly sought him out, as part of his treatment plan, and he also sought her out at least on a weekly basis. Despite all of these potential attachment opportunities and engagement in the spiritual care program activities, Dick's negative and self-injurious behaviors continued to

escalate during the three-month period of this project. Shortly after the project data collection period ended, Dick was hospitalized for potential injury to himself and/or others. He eventually left the hospital but was moved to a higher level of care, a level 14 locked residential care facility.

While Dick did have a great many clinical complications that made his treatment especially difficult, many of the boys at MCC are in this same position. However, one of the more difficult factors contributing to Dick's difficulties was his addiction issues, which he had been fighting for several years, along with his co-occurring depression. It is my guess that these variables increased the difficulties Dick had in finding some healing from his trauma wounds and connecting to any meaningful attachment. Although I believe he truly tried to connect, he often lamented that he just could not get any closer to anybody than he already was.

Hence, although the collected data suggests overall there may be a correlation between participation in the spiritual care program and a decrease in the severity and occurrences of negative self-injurious behaviors, certainly more research is needed to validate that and strengthen the correlation. Moreover, more research needs to be done to limit and identify the extraneous variables, which may account for the boys like Dick who did not appear to benefit from the spiritual care program.

Other variables must be explored, as well. For example, how disruptive is an ongoing addiction or a major mental health diagnosis in attaining an attachment relationship aimed at healing trauma wounds? Do variables such as the gender of the chaplain affect a child's ability to heal? Another boy whom we will call Barney experienced no change in the level of severity of his behaviors or in the number of occurrences of behaviors during the project, although he actively participated in chapel. Barney seldom participated in the other spiritual care program

activities and when asked why, he said he would prefer to interact with a male pastor or chaplain. He said he attended chapel regularly because the girls from The David and Margaret Home, the neighboring girls' residential facility, often came to the Sunday night chapel. However, when it came to the possible one-on-one interactions with a chaplain, while he said he liked Gail, he said he would prefer for those interactions to be with a male. We did facilitate this for him after the culmination of the project and Barney's behaviors have since dramatically lessened in severity, which gives us great reason to hope.

This hope and reduction of visible pain expressed through negative behaviors gave me some hope too. However, it also reminded me of what Reverend Friesen's model had that MCC's did not, what presumably made it more successful, and that is simply more people. In the future, the spiritual care program at MCC needs more people. I believe if there were at least one spiritual care counselor in every cottage, of differing genders and ethnicities, the severe negative attachment-seeking behaviors would continue to decrease, as would the less severe acting-out behaviors. One chaplain at MCC does not have enough time or energy to fill the attachment needs of all these boys. Reverend Friesen's model has at least three times the staff in their spiritual care program and I think it is for this reason that it effects greater change and more easily facilitates attachment healing.

Given the fact that MCC is a nonprofit organization dependent on county and state funding as well as private donations, their future ability to hire and pay more staff for the spiritual care program is bleak. However, perhaps MCC could engage the local colleges and seminaries to offer the MCC spiritual care program as a practicum, intern, or field placement site. Both the boys and the students would benefit from this collaboration; the boys would have

more people to listen to and interact with and the students would learn to listen and interact with their hands, hearts and eyes, not just their mouths, ears and brains.

Furthermore, while it is necessary for MCC to reach out further into the local communities to more churches and more community-based organizations, it is also important for these places to reach back. The community that MCC functions in is the home community of some of the boys. These communities have a responsibility to their children. An expanded volunteer and mentor program, which interacts with the spiritual care program, could be a great possible way to increase the much-needed people. Every volunteer or mentor brings added awareness and increased attachment possibilities.

The creation of the spiritual care program on the campus of MCC was a beginning. More needs to be done. As previously mentioned, this preliminary research project could not control for the many extraneous variables; a longer, more controlled study with a much larger sample size is needed and would provide more conclusive results and suggestions.

Furthermore, a stable, expanded home for the spiritual care program is needed. The attendance has outgrown the facilities and the chapel is not large enough to hold the overflowing crowd on Sunday nights. It is hard to create stability in an unstable, shifting, overcrowded environment.

Ultimately, though, the most important thing for each and every one of these boys is to experience God; God's love with human skin on is a great start. I believe most of these boys need human touch and interaction, human care, and a listening ear, so that their souls and their pains are heard, held, and healed. I believe this project at least hinted at the conclusion that the MCC boys and perhaps other children in residential care settings need something tangible first, a

solid attachment base, to help heal the constant pull of their trauma-induced wounds, before they can expand their hearts and souls to the ultimate attachment figure, God.

There are many things I hope to learn in the future. For example, I want to find out how different variables affect the outcomes of spiritual care within the trauma attachment from the perspectives of trauma theory and attachment theory. Perhaps what I hope to learn most in the future is how to take the terror and loneliness out of the eyes of these boys. Until then, I hope more of us from their community can alleviate their suffering by incarnating God's presence for them through loving and healing attachments.

1

Appendix One

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

- The person has been exposed to a traumatic event in which both of the following were present:
  - the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior
- The traumatic event is persistently reexperienced in one (or more) of the following ways:
  - recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
  - recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
  - acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
  - intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
  - efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - efforts to avoid activities, places, or people that arouse recollections of the trauma
  - inability to recall an important aspect of the trauma
  - markedly diminished interest or participation in significant activities
  - feeling of detachment or estrangement from others
  - restricted range of affect (e.g., unable to have loving feelings)
  - sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
  - difficulty falling or staying asleep
  - irritability or outbursts of anger
  - difficulty concentrating
  - hypervigilance
  - exaggerated startle response

- Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning[251]

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Appendix ~~Two~~

Spiritual Care Attendance September 2008 (sorted by attendance totals)

Name	9/1	2	3	4	7	wkly total	8	9	10	11	14	wkly total	15	16	17	18	21	wkly total	22	23	24	25	28		Month Total	beh SIR	other SIR	Total SIR
1		*	*	*	*	4		*	*	*	*	4			*	*	*	3		*	*			2	13	0	0	0
2	*	*			*	3	*	*			*	3	*				*	2	*				*	2	10	0	0	0
3		*	*	*		3		*	*		*	3			*		*	2		*	*			2	10	0	0	0
4	*	*				2	*	*			*	3	*				*	2	*	*		*		3	10	0	0	0
5	*	*				2	*	*			*	3	*				*	2	*				*	2	9	0	0	0
6	*	*				2	*	*			*	3	*				*	2	*	*				2	9	0	0	0
7	*	*				2	*	*			*	3	*				*	2	*					1	8	1	1	2
8	*	*				2	*	*			*	3	*				*	2	*					1	8	2	0	2
9	*	*				2	*	*			*	3	*				*	2	*					1	8	0	0	0
10	*	*				2	*	*			*	3	*				*	2	*					1	8	0	0	0
11	*	*				2	*	*			*	3	*				*	2	*					1	8	0	1	1
12	*	*				2	*	*			*	3	*				*	2	*					1	8	0	0	0
13	*	*				2	*	*			*	3	*				*	2	*					1	8	1	0	1
14				*	*	2					*	1		*			*	2		*			*	2	7	0	0	0
15		*		*	*	3		*			*	2					*	1						0	6	0	0	0
16		*			*	2		*			*	2					*	1					*	1	6	1	1	2
17		*		*		2		*			*	2					*	1		*				1	6	1	0	1
18		*			*	2		*			*	2					*	1						0	5	0	0	0
19		*			*	2		*			*	2					*	1						0	5	0	0	0
20				*	*	2					*	1					*	1		*				1	5	0	0	0
21		*				1		*			*	2					*	1		*				1	5	1	0	1
22					*	1					*	1					*	1	*				*	2	5	1	0	1
23						0					*	1				*	*	2		*		*		2	5	0	0	0
24				*	*	2					*	1					*	1						0	4	0	1	1
25		*				1		*			*	2					*	1						0	4	2	0	2
26		*				1		*			*	2					*	1						0	4	3	1	4
27		*				1		*			*	2					*	1						0	4	0	1	1
28				*		1					*	1				*	*	2						0	4	1	3	4
29					*	1					*	1					*	1		*				1	4	1	0	1
30						0					*	1				*	*	2				*		1	4	0	0	0
31				*		1					*	1					*	1						0	3	0	2	2

Appendix ~~Two~~ 2

Spiritual Care Attendance September 2008 (sorted by attendance totals)

Name	9/1	2	3	4	7	wkly total	8	9	10	11	14	wkly total	15	16	17	18	21	wkly total	22	23	24	25	28		Month Total	beh SIR	other SIR	Total SIR
32					*	1					*	1					*	1						0	3	0	0	0
33					*	1					*	1					*	1						0	3	0	0	0
34					*	1					*	1					*	1						0	3	1	0	1
35					*	1					*	1					*	1						0	3	0	2	2
36						0					*	1					*	1					*	1	3	0	1	1
37						0					*	1		*			*	2						0	3	0	0	0
38						0					*	1				*	*	2						0	3	0	0	0
39						0					*	1				*	*	2						0	3	0	1	1
40						0					*	1				*	*	2						0	3	0	0	0
41						0					*	1					*	1						0	2	0	1	1
42						0					*	1					*	1						0	2	0	0	0
43						0					*	1					*	1						0	2	0	1	1
44						0					*	1					*	1						0	2	0	0	0
45						0					*	1					*	1						0	2	0	1	1
46						0					*	1					*	1						0	2	2	0	2
47						0					*	1					*	1						0	2	0	1	1
48						0					*	1					*	1						0	2	0	0	0
49						0					*	1					*	1						0	2	1	0	1
50						0					*	1					*	1						0	2	0	0	0
51						0					*	1					*	1						0	2	0	0	0
52						0					*	1					*	1						0	2	0	0	0
53						0					*	1					*	1						0	2	0	0	0
54						0					*	1					*	1						0	2	0	0	0

3.

Appendix Three

Spiritual Care Attendance October 2008 (sorted by attendance totals)

Name	9/29	30	10/1	2	5	wk total	6	7	8	9	12	wk total	13	14	15	16	19	wk total	20	21	22	23	26	wk total	Month total	beh SIR	oth SIR	SIR total
40		*		*	*	3				*	*	2			*	*		2			*	*		2	9	0	0	0
24		*	*	*	*	4		*		*	*	3						0						0	7	0	1	1
30		*		*	*	3				*	*	2				*		1			*			1	7	0	1	1
44		*		*	*	3				*	*	2				*	*	2						0	7	0	0	0
55		*			*	2	*				*	2						0	*	*			*	3	7	0	0	0
28		*		*	*	3				*	*	2			*			1						0	6	6	0	6
4	*	*				2	*				*	2						0	*				*	2	6	0	0	0
3				*	*	2	*			*	*	2						0	*		*			2	6	0	0	0
1				*	*	2				*	*	2						0			*		*	2	6	0	0	0
33		*			*	2					*	1						0	*	*			*	3	6	0	1	1
39		*			*	2					*	1			*	*		2			*			1	6	0	0	0
36		*	*		*	3		*			*	2						0						0	5	1	0	1
27		*			*	2					*	1						0		*			*	2	5	0	0	0
15				*	*	2				*	*	2					*	1						0	5	1	1	2
20				*	*	2				*	*	2						0					*	1	5	0	0	0
22			*		*	2		*			*	2						0	*					1	5	0	1	1
41				*	*	2				*	*	2					*	1						0	5	1	0	1
23		*			*	2					*	1				*		1			*			1	5	0	0	0
26				*	*	2				*	*	2						0			*			1	5	0	2	2
54		*			*	2					*	1				*		1			*			1	5	0	0	0
7	*					1	*				*	2						0	*				*	2	5	0	0	0
5	*					1	*				*	2						0	*				*	2	5	0	0	0
2	*					1	*				*	2						0	*				*	2	5	0	0	0
11	*					1	*				*	2						0	*				*	2	5	0	0	0
12	*					1	*				*	2						0	*				*	2	5	0	0	0
13	*					1	*				*	2						0	*				*	2	5	0	0	0
45				*		1				*	*	2					*	1					*	1	5	0	0	0
21				*	*	2				*	*	2						0						0	4	0	2	2
29				*	*	2				*	*	2						0					*	0	4	0	1	1
34		*			*	2					*	1						0					*	1	4	1	0	1
47			*		*	2		*			*	2						0						0	4	0	2	2

Appendix ~~Three~~ 3

Spiritual Care Attendance October 2008 (sorted by attendance totals)

Name	9/29	30	10/1	2	5	wk total	6	7	8	9	12	wk total	13	14	15	16	19	wk total	20	21	22	23	26	wk total	Month total	beh SIR	oth SIR	SIR total
49			*		*	2		*			*	2						0						0	4	0	0	0
50		*			*	2					*	1				*		1						0	4	0	0	0
56			*		*	2		*			*	2						0						0	4	0	0	0
8	*					1	*				*	2						0	*					1	4	0	1	1
9	*					1	*				*	2						0	*					1	4	0	2	2
10	*					1	*				*	2						0	*					1	4	0	0	0
6	*					1	*				*	2						0	*					1	4	2	0	2
17				*		1				*	*	2						0			*			1	4	0	0	0
14					*	1					*	1				*	*	2						0	4	0	1	1
16		*			*	2					*	1						0						0	3	1	2	3
18		*			*	2					*	1						0						0	3	0	1	1
25		*			*	2					*	1						0						0	3	4	2	6
26		*			*	2					*	1						0						0	3	0	0	0
46		*			*	2					*	1						0						0	3	0	0	0
51		*			*	2					*	1						0						0	3	0	0	0
19					*	1	*				*	1						0	*					1	3	0	0	0
31			*			1		*			*	2						0						0	3	0	0	0
32					*	1					*	1						0							2	1	0	1
35					*	1					*	1						0						0	2	1	0	1
42						0					*	1						0						0	1	1	0	1
43						0					*	1						0						0	1	0	0	0
37						0					*	1						0						0	1	0	0	0
48						0					*	1						0						0	1	0	0	0
52						0					*	1						0						0	1	0	0	0
53						0					*	1						0						0	1	0	0	0
57						0						0						0		*				1	1	0	0	0
58						0						0						0			*			1	1	0	0	0
59						0						0						0			*			1	1	0	1	1

Appendix Four

Spiritual Care Attendance November 2008 (sorted by attendance totals including week 5)

Name	10/27	28	29	30	11/2	wk total	3	4	5	6	9	wk total	10	11	12	13	16	wk total	17	18	19	20	23	wk total	mth Total	beh SIR	oth SIR	SIR Total
33		*			*	2	*	*	*		*	4	*	*		*	*	4	*	*			*	3	18	0	0	0
55	*	*	*		*	4	*	*	*		*	4	*	*	*	*	*	5	*	*				2	17	0	0	0
27		*		*	*	3	*	*	*		*	4	*	*		*	*	4		*	*			2	15	0	0	0
43		*	*		*	3			*		*	2	*	*	*	*		4		*	*		*	3	14	0	0	0
18		*	*	*		3		*	*		*	3	*	*		*	*	4			*			1	12	0	0	0
10		*	*		*	3		*	*		*	3	*	*		*		3						0	11	0	0	0
40		*	*	*	*	4			*		*	2		*		*		2				*		1	11	0	0	0
16		*	*		*	3		*			*	2	*	*		*		3			*			1	11	1	1	2
25		*	*			2			*		*	2		*		*	*	3			*			1	10	4	2	6
38		*				1			*		*	2		*	*	*	*	4			*		*	2	10	1	0	1
30		*		*	*	3					*	1		*		*		2			*			1	9	2	0	2
44		*			*	2					*	1	*	*		*		3						0	8	0	0	0
50		*				1					*	1		*		*		2			*			1	7	0	0	0
29					*	1			*		*	2				*	*	2					*	1	7	0	0	0
23		*		*		2					*	1		*		*		2			*			1	7	0	0	0
3					*	1				*	*	2				*		1	*		*			2	7	0	0	0
39		*				1			*		*	2		*		*		2			*			1	7	0	0	0
28		*				1					*	1		*		*	*	3			*			1	7	1	1	2
19		*				1					*	1		*		*		2	*		*			2	7	1	3	4
17				*	*	2					*	1				*		1			*		*	2	7	2	0	2
5	*				*	2					*	1				*		1	*					1	6	0	0	0
58		*				1					*	1		*		*		2			*			1	6	0	0	0
2	*				*	2					*	1				*		1	*					1	6	0	0	0
12	*				*	2					*	1				*		1	*					1	6	0	0	0
6	*				*	2					*	1				*		1	*					1	6	0	0	0
59		*				1					*	1		*		*		2			*			1	6	0	2	2
45				*	*	2					*	1				*		1			*			1	6	0	0	0
13	*				*	2					*	1				*		1	*					1	6	0	1	1
7	*				*	2					*	1				*		1	*					1	6	0	0	0
22					*	1					*	1				*		1	*		*			2	6	1	1	2
34		*				1					*	1		*		*		2						0	5	3	1	4

Appendix ~~Four~~ 4

Spiritual Care Attendance November 2008 (sorted by attendance totals including week 5)

Name	10/27	28	29	30	11/2	wk total	3	4	5	6	9	wk total	10	11	12	13	16	wk total	17	18	19	20	23	wk total	mth Total	beh SIR	oth SIR	SIR Total
54		*				1					*	1		*		*		2						0	5	0	0	0
20						0					*	1				*	*	2			*		*	2	5	0	0	0
36		*				1					*	1		*		*		2						0	5	0	1	1
46		*				1					*	1		*		*		2						0	5	0	0	0
4	*					1			*		*	2				*		1	*					1	5	0	0	0
51		*				1					*	1		*		*		2						0	5	0	1	1
24		*				1					*	1		*		*		2						0	5	0	0	0
26				*		1					*	1				*	*	2					*	1	5	0	0	0
1					*	1					*	1				*		1			*			1	5	0	0	0
14						0					*	1				*	*	2					*	1	5	0	1	1
41						0					*	1	*			*		2			*			1	4	1	1	2
37				*		1					*	1				*	*	2						0	4	0	0	0
32	*					1					*	1				*		1	*					1	4	0	0	0
60						0						0						0					*	1	4	1	1	2
8	*					1					*	1				*		1	*					1	4	0	0	0
15						0					*	1				*	*	2			*			1	4	0	0	0
11	*					1					*	1				*		1	*					1	4	2	1	3
9	*					1					*	1				*		1	*					1	4	0	0	0
56						0					*	1				*		1			*			1	3	1	1	2
49						0					*	1				*		1			*			1	3	0	0	0
21						0					*	1				*		1			*			1	3	0	0	0
47						0					*	1				*		1			*			1	3	0	0	0
48						0					*	1				*		1			*			1	3	0	0	0
57						0					*	1				*		1			*			1	3	0	0	0
31						0					*	1				*		1			*			1	3	0	0	0
35						0					*	1				*		1						0	2	0	1	1
42						0					*	1				*		1						0	2	0	0	0
52						0					*	1				*		1						0	2	0	0	0
53						0					*	1				*		1						0	2	0	0	0

4A

Appendix ~~Four A~~

Spiritual Care Attendance Fifth Week of November 2008 (sorted by attendance)

Name	11/25	26	27	28	11/30	wk total
33	*	*	*	*	*	5
55		*			*	2
27		*			*	2
43		*			*	2
18		*				1
10		*			*	2
40		*			*	2
16		*			*	2
25		*			*	2
38		*				1
30		*			*	2
44		*			*	2
50		*			*	2
29					*	1
23		*				1
3					*	1
39		*				1
28		*				1
19		*				1
17					*	1
5					*	1
58		*				1
2					*	1
12					*	1
6					*	1
59		*				1
45					*	1
13					*	1
7					*	1
22					*	1
34		*				1

4A

Appendix ~~Four A~~

Spiritual Care Attendance Fifth Week of November 2008 (sorted by attendance)

Name	11/25	26	27	28	11/30	wk total
54		*				1
20						0
36		*				1
46		*				1
4						0
51		*				1
24		*				1
26					*	1
1					*	1
14					*	1
41						0
37						0
32						0
60	*		*		*	3
8						0
15						0
11						0
9						0
56						0
49						0
21						0
47						0
48						0
57						0
31						0
35						0
42						0
52						0
53						0

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